

SOME THOUGHTS ON THE
PRINCIPLES OF LOCAL TREAT-
MENT IN DISEASES OF THE
UPPER AIR PASSAGES

SIR FELIX SEMON M.D. F.R.C.P.

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BEING

*Two Lectures Delivered at the Medical
Graduates' College and Polyclinic on
October 2nd and 9th, 1901*

*With an Appendix consisting of Two Letters published on November 23rd, 1901,
and on January 11th, 1902, in the "British Medical Journal"*

BY

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PREFACE

THE two lectures which form the bulk of the present little volume were delivered on October 2nd and 9th, 1901, at the Medical Graduates' College and Polyclinic, and were published in the *British Medical Journal*, November 2nd and 9th, 1901. The publication of the second lecture was accompanied by a leading article, entitled "A Protest against Operative Intemperance," in which the views expressed in the lectures were warmly endorsed. They were, however, not allowed to pass unchallenged. A fierce discussion arose, in which sixteen different writers took part, and which was carried on in every number but one (December 7th) of the *British Medical Journal* published between November 16th, 1901, and January 11th, 1902. On the last-named date I summed up the results of the controversy; the Editor of the *Journal* declared the discussion closed, and in an Editorial Note, entitled "Local Treatment in the Upper Air Passages," expressed his full concurrence with my conception of its results.

From various quarters the wish has been expressed that the lectures should be published in separate form.

Whilst gladly complying with this desire, I should have wished to reprint, in the form of an appendix, all the letters exchanged in the controversy, and the two Editorial articles of the *British Medical Journal* referring to the subject. Unfortunately, the state of the copyright law does not permit me to do so. I have, therefore, only added the first and the last of my own letters, as they are fully intelligible by themselves, and give instructive information on the nature of the opposition raised against the views expressed in my lectures. Those who wish for fuller information must be referred to the columns of the *British Medical Journal*.

The lectures themselves are simply reprinted with a few unimportant verbal alterations and corrections.

FELIX SEMON.

January 11th, 1902.

SOME THOUGHTS ON THE PRINCIPLES OF LOCAL TREATMENT IN DISEASES OF THE UPPER AIR PASSAGES

LECTURE I

Introduction.

GENTLEMEN,—In the remarkable address on “Friends in Council” recently delivered before the British Medical Association at Cheltenham, and in which both the profession and the public got to hear a number of excellent, though perhaps not exactly palatable, home truths, Dr. Goodhart in speaking of “patients” makes the following statement:—“With what impatience do men and women in the present day rush into the not always sufficiently repellent arms of surgery. A little pain unnerves them, and all they know of surgery is its successful side. It is a day of great things, and why should they not have the benefit of these advances? And so with an ache here or a pain there they undergo an operation.” And further on he says of “doctors”:—“I do not doubt, I say, that every one of us does his best for the man that consults him, but I am not sure that in attending to the

exigencies of the immediate present we do sufficiently take heed of the future. And our failings in this respect are closely bound up with those of our patients, for we in our place are so anxious to overlook nothing and to cure disease; so enthusiastic in our belief in our power to accomplish what we wish. First may be put a morbid readiness on our part to detect disease. Engaged as we are in this pursuit, there comes a risk that we too little appreciate the wide range of health—that is, how good a state of health is compatible with numberless slight and even sometimes considerable departures from normal. We tend to make our standard too severe for practical purposes.”

It did not require Dr. Goodhart’s further specific charge, namely, that “throats and noses suffered terribly from this lust of operation that has beset the public,” to convince me that I could not do better than introduce what I have long intended to say on the question of the principles of local treatment in diseases of the upper air passages, by quoting the above wise words, for they tersely and accurately describe, in my opinion, the present state of the question. Not that I wish to bring a special charge against my own special branch. Dr. Goodhart’s fearless denunciation shows that the “lust of operation” is, indeed, a general characteristic of the present phase of medical development. But coming from the general to the particular, and speaking of such matters only of which I can claim personal cognisance, I am afraid I must fully endorse his statement so far as diseases of the upper air passages are concerned. Not only is local or operative treatment

of these parts resorted to in numberless cases, where, to say the least, it is not required ; not only do operations of inestimable value in really suitable cases become discredited through being performed wholesale ; not only is the old war-cry against specialism, namely, that it engendered narrow-mindedness, heard again, and this time, I am afraid, with greater justification than on previous occasions ; but, worst of all, laryngology and rhinology as a whole are being held responsible for the over-zeal of one advanced section.

Under these circumstances no apology is needed for a serious protest coming from within against the "lust of operation," and for an attempt to propose some simple principles which might advantageously guide our local activity in diseases of the upper air passages. This is the purpose of my lectures. Before I have gone far, you will have seen, I trust, that declaring against exaggerations does not in the least mean counselling procrastination or giving pusillanimous advice in cases in which prompt and energetic local interference is actually required.

The Rationale of Local Treatment.

Let me begin, then, by recording my own conviction that it is in the nature of things, when a part of the human body has been made more accessible to eye and hand by the progress of our science, that the treatment of affections of that part should gradually change from the medical to the surgical, or, at any rate, from the general to the topical side. The *rationale* of

this change is obvious. Instead of pouring, as it has been satirically described, “drugs of which we know little into a body of which we know less,” with the sometimes rather vague hope that some of the constituents of our mixture may reach and favourably influence the affection from which our patient suffers, we, by the substitution of local for general treatment, either modify by topical applications, the effect of which can be accurately watched, the course of the disease, or, in another number of cases, remove it altogether by surgical interference. That such a change, broadly speaking, is almost always of the nature of a distinct therapeutical advance—although, as will be hereafter shown, important exceptions exist to that rule—is conclusively proved by the increase of our healing power during the last fifty years.

The triumphs of cerebral and abdominal surgery admit of no dispute, and, were further proof needed, it is given by the great progress we have made in the treatment of diseases of the upper air passages. Where forty years ago the practitioner treated the symptom “hoarseness” by drugs and climatic changes, often enough in complete ignorance whether that symptom depended upon a simple catarrhal inflammation, upon syphilis, tuberculosis, an innocent growth, malignant disease, or paralysis of the larynx, we are now enabled not merely to accurately differentiate between these contingencies, but also to actually cure by topical applications or operation, if not all, yet certainly the majority, of the diseases named. Where thirty years ago the child who could not breathe through the nose

and kept its mouth open was censured by parents and governesses for this "bad habit," and was allowed to grow up with retracted chest, deformed face, crippled in its general development, and living under a constant cloud of ear complications, we now, by the removal of adenoid vegetations, obtain—in really suitable cases, be it said—an equally surprising and pleasing change for the better in all these respects. Where twenty years ago patients suffering from what was at that time called "chronic nasal catarrh," accompanied by frequent frontal headaches and by symptoms referable to the absorption of the poisonous discharge which they constantly swallowed during the night into the digestive organs, were treated with sedatives, stomachics, changes of air, and equally harmless and useless snuffs, we now discover in many such cases the cause of all the trouble in an empyema of one or another of the nasal accessory cavities, and by surgical treatment relieve the patient lastingly.

These illustrations could be easily multiplied, but they will suffice, I think, to show the great and manifold progress made through the introduction of local treatment in a number of equally frequent and troublesome affections of the upper air passages.

Exaggeration of Local Treatment.

Whilst this must be unreservedly, and, indeed, most gratefully, acknowledged, it is a very different question whether the length to which the substitution of local for general treatment has gone has been an unmixed blessing. Unfortunately, in almost every sphere of

human activity the most useful and desirable innovations are apt to be exaggerated, and, indeed, it would almost seem that this danger is the greater in proportion to the intrinsic value of the original movement. Whilst illustrations of this may be seen almost daily in art, in commerce, in industry, and in science, a study of the development of modern medicine in particular, will show that, in spite of many disappointing experiences, almost every progress in our art is apt to become at first disproportionately exaggerated, later on equally disproportionately depreciated, and finally to emerge often enough, if at all, with considerable diminution of its original prestige.

Need I mention the indiscriminate recommendation of many excellent remedies, which, though effectual enough in certain definite diseases, were at one time advocated for every disease under the sun ; the boundless, but so soon blighted, hopes after the introduction of tuberculin ; the excessive employment in bygone days of electricity as a therapeutical agent ; and particularly the hyperactivity which we see so often follow the introduction of new and in themselves excellent operations ?

What has always appeared to me most remarkable when reviewing these experiences is that the lessons they teach should be taken so little to heart. Time after time one sees that, nothing daunted by the most recent and unpleasant experiences of a similar kind, exaggerations of a truly astounding nature are again indulged in as soon as a hopeful medical progress is made, and again and over again one witnesses the com-

pletion of the cycle of overestimation, underrating, and return to soberness.

The method of local treatment of diseases of the upper air passages has, I am sorry to say, not formed an exception to the course of events just sketched. More than once it has had to pay the penalty of its success, and it still pays it periodically, whenever a promising innovation is being made. There is no better illustration of this than the whole history of modern rhinology. Comparing our present knowledge of diseases of the nose with what it was twenty years ago, there cannot be the least doubt that much important progress has been made. But no sooner was a hopeful rhinological innovation introduced than it was most grossly exaggerated, and no sooner had the exaggeration been recognised and minds had begun to cool down, than the place of the old idol was taken by a new fetish, which in turn was worshipped with equal enthusiasm.

It suffices to remind you of necrosing ethmoiditis, of the nasal reflex neuroses, of the deflections and spurs of the nasal septum, of the hypertrophies of the posterior ends of the lower turbinated bodies, of the latest fad—the “physiological insufficiency” of nasal breathing—and of all the exaggerated hopes and unnecessary operations in turn connected with these conditions, which during the last twenty years have relieved one another like sentinels on guard, to prove that my description is anything but fantastic. Whether it be increased facility of diagnosis; be it the undeniable triumphs obtained in many affections of the nose and

throat, which formerly ranked amongst the incurable ; be it an ever-growing conviction on the part both of the profession and the public, that *all* affections of these parts ought to be locally treated ; be it the modern teaching that a large number of the most obscure diseases of the human race, even if situated in remote parts of the body, are in reality due to affections of the upper air passages ; be it, as it probably is, a combination of all these factors, there can hardly be any doubt, I think, that local, and more particularly operative, treatment of these parts, excellent as it is in really suitable cases, has of late years been considerably overdone, and that there is a marked tendency to further overdo it.

In this connection it is interesting to inquire who have been the greater sinners, the profession or the public ? Dr. Goodhart seems to think that the greater share of the blame falls upon the public. He argues, if I understand him correctly, that the modern patient forces his doctor's hands by demanding a certain article from him, and that the latter only errs by yielding to that demand. Undoubtedly there is a good deal of truth in that argument, and nowhere perhaps is this more evident than in the subject now under consideration. The public themselves have become so keenly alive to the great progress made, thanks to the introduction of local treatment, in the therapeutics of so many of the affections of the upper air passages, that they have rushed to the conclusion, though very faulty, yet perfectly feasible and pardonable, that *all* diseases of these parts are amenable to local treatment and

ought to be treated locally. They therefore consult the doctor, and particularly the specialist, with the set notion that either some local application will be prescribed for them, or that some operation will be performed. How often do I see undisguised disappointment on a face when I have explained to its owner that his case was one for general, not for topical treatment; how often do I hear, when I think I have succeeded in making it quite clear to a patient that his local sensations depended upon disturbances of his general health, which in reality required being attended to, "But won't you give me a gargle?" It very much depends upon the doctor's strength of mind, whether he will under such circumstances insist upon the line which he himself considers to be the right one, or whether he will flatter the patient's whims by giving him an innocent local placebo in addition to the constitutional treatment which is obviously indicated. There is undoubtedly something to be said in favour of the latter alternative. As Dr. Goodhart truly remarks: "There are times when the sick are not reasonable beings, and unless they have a bottle of medicine"—or shall we in our special case say a gargle, or a paint, or an inhalation?—"to anchor their faith to (oh, shifting sands!), they are in a state of unrest that is positively harmful to their progress." That is certainly true. And, further, when with a little knowledge of the world, and with plenty of previous experiences to guide one, one sees that the patient, disappointed at not getting what he wants, thinks: "That doctor does not understand my complaint," and that he is sure to fall into the hands of the topical enthusiast,

or of somebody worse, who will be equally sure to mulct him in a perfectly unnecessary operation, one is confronted by the difficult question whether in the patient's own interest it would not have been better to comply with his wish and to give him something local which, if absolutely useless, would have been at any rate equally harmless, and would have set his mind at rest. I dare not say that this "*pia fraus*" must never be practised. But against it are three very grave reasons, which I would particularly recommend to your consideration. In the first place, when prescribing some local application, which, of course, has to be repeated at stated intervals, you involuntarily become the patient's accomplice by concentrating his mind on his local sensations, whilst in his own interest you ought by all possible means to divert it from them. Secondly, you lend yourself to supporting the general notion, which you know is neither correct nor desirable, namely, that *all* affections of the upper air passages ought to be treated locally. And, thirdly, and most serious of all, by yielding to the temptation you may unconsciously, and with the best intentions in the world, yet very actually, transgress the line between legitimate practice and quackery. Under all circumstances, therefore, the pious deception of which I have just spoken ought to be practised only in the rarest of cases, and the doctor ought to stiffen his back and harden his heart against meekly complying with every unreasonable wish expressed by an unreasonable patient. Better, I think, to lose such a one if he will not listen to well-meant advice than to have to confess to yourself

that you have descended to the level of habitually acting against your own better conviction.

But, gentlemen, can we really lay the flattering unction to our souls that in this whole matter the public is the sole tempter, and that our profession merely sins passively by yielding to the temptation? I must confess I do not think that question can honestly be answered in the affirmative. In my opinion and experience the "lust of operation" (including in the word "operation" other forms of local treatment as well) besets not only the public, but also a considerable number of doctors, and I think it cannot be seriously questioned that in the great majority of cases the initial suggestion of operative or local interference comes, not from the patient, but from the medical adviser himself. It will, of course, be said: that is as it ought to be, and I certainly am the last person to dispute that the initiative of any treatment should be taken by the doctor, instead of his hands being forced by the patient. What I maintain is that the frequency with which local interference is advised and practised nowadays is unfortunately far in excess of actual requirements; that operations are performed wholesale where they are not needed, that operative proposals are being made and carried out on an extensive scale on the basis of some unproven theory, and that the operative interference itself, often enough, is unduly severe and protracted in proportion to the smallness of the complaint for which it is undertaken. It will be my duty further on, when we come to details, to substantiate these serious assertions, and I feel confident

that I shall be able to do so, but I have again to touch upon that sore question, which formed the starting-point of my observations, in the present connection, because I do not think it fair to lay the whole blame of the modern "lust of operation" upon the public alone, and because I honestly believe that the operative Hotspurs amongst ourselves deserve at least an equal share of reprobation.

This, I trust, is neither a rash nor an uncharitable statement. Whilst making it I am fully aware that in questions of treatment there is very often legitimate room for considerable differences of opinion; that the more enthusiastic and therapeutically active section of our profession is actuated by motives as honourable as those of the more sceptical section, and that to the former we are indebted for most of the therapeutical advances of the present day. But when all these reservations have been made and duly considered, there remains no doubt in my mind that there are not a few amongst us who are, as Dr. Goodhart has put it, "so enthusiastic in their belief in their power to accomplish what they wish," that their zeal but too often greatly outruns their discretion. Starting with a "morbid readiness to detect disease," they suspect the cause of all ills to which human flesh is heir to be situated in their own favourite little nook, and, when they detect the smallest deviation from the normal there, they persuade themselves that they have discovered the true source of the patient's complaint, and immediately proceed to demolish it with fire and sword.

Indeed, your "radical localist" is a much more

formidable and actively mischievous person than the poor country practitioner who caustics his influential patient's throat because the latter insists that "something should be done" for him! Whilst he of the country succumbs occasionally—*parce qu'il faut vivre*, as the tailor said to Talleyrand—the thorough believer in local disease and local treatment *quand même* slaughters hecatombs of his own free will! In every patient that enters his consulting-room he sees a prey to the arrow of his local treatment, and when he writes or speaks of his experiences, you read or hear with astonishment of the dozens or hundreds of cases in which he has found it necessary to perform certain operations and in which he has obtained "excellent results," whilst moreover you, with a not altogether contemptible practice of your own, can recollect but a few cases in which you have considered the operation in question indicated, and whilst you happen to know that the subsequent experiences of some of the patients on whom these operations had been performed by their perfervid advocate do not by any means justify his glowing account!

The funniest part of the whole business—if in such serious matters one may speak of fun at all—is, that almost every one of the stalwart fraternity has some pet operation of his own, to which he apparently resorts under all circumstances. I confess to serious misgivings when I see it stated that Dr. X. opened more than 500 maxillary antra within a comparatively few years; that Dr. Y. finds it necessary to employ the nasal saw "almost daily," and that Dr. Z. discovers

“varicose veins” at the base of the tongue or in the pharynx in every third or fourth patient, necessitating, it would appear, in his opinion, the application of the galvano-cautery in a goodly proportion of them. Statements of that kind, which are not at all uncommon nowadays, justify, I am afraid, more than sufficiently, the ever-growing feeling against local over-activity in this territory of medicine, which he who runs cannot help having observed of late—a feeling, let me assure you, which is shared by no one more strongly than by the large moderate section of laryngologists and rhinologists, who, from the nature of their calling, have probably more opportunity of seeing what is going on than the profession at large, and who, I repeat, resent it the more keenly, as their whole speciality is held responsible for the excessive activity of its radical section. They see with sincere regret that a revolt is preparing against particular operations and forms of local treatment, which in suitable cases are most useful, but in which the therapeutic zeal of the localist has been most conspicuous and aggressive of late years. They foresee from analogous experiences that the reaction which is brewing may engulf, not only the excesses, against which it is directed, but the method itself, excellent though it be in really suitable cases. I feel sure that before this a protest would have been raised from their midst against what they themselves consider as excessive zeal, had not the same easily intelligible personal considerations, which have for a long time prevented me from speaking out, also, with one exception to which I shall further on specially refer, tied

their tongues and pens. At last, however, the time appears to have come, when it would seem almost a duty to criticise fearlessly the present state of matters, and to try and bring about a greater consensus of opinion than prevails nowadays concerning the principles which ought to guide us in the local treatment of affections of the upper air passages.

The Difficulties of laying down General Principles.

That complete unanimity concerning these principles will ever be obtained I do not venture to hope myself. Two circumstances prevent such a happy consummation.

First of all, as I have just endeavoured to show, the personal element enters so largely into all questions of treatment, both so far as the patient's and as the medical adviser's temperaments are concerned, that no universal formula will ever be found applicable to all cases. So long as there shall be differences in education, in intellect, in character—and these differences will of course continue to the end of the chapter—we shall have to shape our treatment in accordance with the peculiarities of each individual patient, and on what this treatment should be the opinions of medical optimists and pessimists will vary equally persistently.

The second point which tells against the laying down and the adoption of any general principles in the treatment of diseases of the upper air passages is the undeniable fact that our views as to whether local or general treatment should be adopted are so liable to be changed by any new discovery, that what seemed essential and

indeed indispensable yesterday, may be completely thrown over to-morrow. In the introductory passages of this lecture it has been stated that whilst nowadays the treatment of these affections usually progresses from the general to the topical, we were occasionally met by a movement in the opposite direction. The best illustration of the truth of this statement is afforded by the modern history of the treatment of diphtheria. Whilst, of course, general measures were never neglected by thoughtful physicians in the therapeutics of that formidable disease, the local treatment of its local phenomena developed more and more as time went on. Caustics and astringents, resolvents and antiseptics, heat and cold, varnishes, papaine, peroxide of hydrogen, and a legion of other local applications were recommended and assiduously used to stop the local process. All of a sudden the serum treatment is introduced, and, behold, equally suddenly an end is made of almost all the local therapeutics. True, cleansing remedies and various inhalations are still used, and intubation or tracheotomy may still be required by way of local treatment, but on the whole there can be no question that local has been victoriously superseded by general treatment in this important disease.

What we have witnessed in diphtheria we are likely to see not infrequently repeated, possibly in the near future, in other affections also, if, as may be fairly hoped, further progress should be made with the anti-toxin and serum treatment. Whilst, unfortunately, there can be hardly any doubt that the tuberculin treatment in its original form was prematurely inaugurated

and adopted, it appears to me equally certain that Koch's fundamental idea was a most important move in the right direction, and it may justly be hoped that, with further perfection of the method, we may some day succeed in killing the tubercle bacillus in the living tissues of the body without damaging the latter. When that goal has been achieved, there will in all probability be an end to, or, at any rate, very little further necessity for, the surgical treatment of local manifestations of tuberculosis. Hence, all the local measures in, say, tuberculosis of the larynx, such as curetting, lactic acid applications, etc., which we at this moment justly look upon as important advances in the treatment of one of the most cruel complications of pulmonary tuberculosis, may one day all of a sudden come to belong to the curiosities of a bygone age! And unless it be considered too utopian, it may even be hoped that the day will dawn when what has been obtained in diphtheria and in syphilis, and what may fairly be looked for in tuberculosis, may also be obtained in that most cruel of all human scourges—cancer.

From the foregoing you will have seen, gentlemen, that I am very far from flattering myself that any principles of local treatment of the upper air passages which may be proposed have any chance of becoming universally adopted or of being eternally followed. But when all has been said and freely admitted, enough remains which makes it urgently desirable that in our own day a greater consensus of opinion should be obtained as to what is desirable in the way of local treatment of diseases of the upper air passages, and how it should be

carried out, than exists at the present moment. The future will have to take care of itself.

In the following it is, of course, not my intention to discuss separately or even indeed to mention every single disease of the upper air passages, to describe every indication for its local treatment, or to enter upon operative technicalities. Quite apart from the fact that the time at my disposal is much too short to allow of such an ambitious scheme, it would frustrate, I am afraid, my very purpose. For I should have to go into such a mass of details that amongst them sight might be lost of the general principles which, in my opinion, ought to govern our actions in this class of affections. It is with these I am mainly concerned. With regard to a few important and frequent diseases only, such as adenoid vegetations and laryngeal tuberculosis, shall I enter into details, because experience has shown that even with regard to such details some general principles of thought and action are required. For the rest, if the ideas which I am going to lay before you should be found worthy of your acceptance, it will not be difficult for you, I believe, to evolve from them a line of guidance in contingencies and affections which I may not happen to mention at all.

For my special purposes the symptoms and objective manifestations arising in pathological conditions of the upper air passages may be subdivided into the following categories :—

1. Affections of a purely local character.

2. Local manifestations of general or systemic diseases.

3. Local manifestations in nose and throat dependent upon local diseases in correlated areas.

4. Affections of the upper air passages, supposed to exercise an influence upon other organs and parts of the body. This influence may be: (*a*) of a direct character; (*b*) of a reflex character.

5. Local symptoms and sensations of obscure origin.

(A certain amount of overlapping is inevitable in adopting these subdivisions, but it will be minimised as much as possible.)

In conclusion, I shall have to make some observations on :

6. The necessity of a proper proportion being observed between the gravity of the disease and that of the interference.

1. AFFECTIONS OF THE UPPER AIR PASSAGES OF A PURELY LOCAL CHARACTER.

It goes without saying that as a rule the question whether local treatment should be adopted or not in a given case will be easiest to decide in the class of diseases now under consideration. Indeed, it may be stated as a general principle that if a disease of the upper air passages be (*a*) purely local, (*b*) causing considerable local discomfort or serious disturbance of the general health, and (*c*) amenable to local treatment—such should be adopted forthwith, without precious time

being lost by a policy of mere waiting or by constitutional treatment, the effect of which in almost all such affections is at best extremely doubtful and in most *nil*.

You see, gentlemen, my proposition is, in all conscience, broad and radical enough to satisfy the most thoroughgoing localist. It embraces acute and chronic inflammations, abscesses, new growths, foreign bodies, hypertrophy of glands, all the various forms of obstruction, and, indeed, any other affections of the nose, nasopharynx, pharynx, larynx, or trachea, the purely local character of which can be ascertained and the nature of which demands active measures. But it limits the indication for active measures to cases in which they are really needed, by stipulating that they should only be adopted if the affection in question causes either considerable local discomfort or seriously disturbs the general health. And in this demand lies the crux of the whole question. No reasonable person will object to the removal of a nasal obstruction which almost entirely abolishes nasal breathing, and in addition causes dry pharyngitis and great liability to laryngeal and bronchial catarrh; to the radical operation of a chronic frontal sinus empyema, which produces violent frontal headache, gastric symptoms, grave disturbances of the general health, and makes life altogether unbearable; to the removal of adenoids, which seriously interfere with the little patient's breathing and hearing and gravely jeopardise his chance of growing into a strong and healthy person; or to the removal of a laryngeal papilloma or fibroma which renders the patient aphonic and threatens to choke him. I repeat: In all such, and in a

large number of similar cases, it will be the practitioner's obvious duty to at once attack the local disease by energetic local measures, and I am so far from counselling a weak attitude in this class of cases, that on the contrary I wish to avail myself of this opportunity to strongly urge again, as I have done more than once before, greater energy in two classes of affections, in which one sees but too often the lamentable consequences of a policy of ignorance and procrastination. I refer to foreign bodies in the upper air passages, and, particularly, to malignant disease of the larynx.

Foreign Bodies in the Upper Air Passages.

With regard to foreign bodies it ought to be a fundamental principle: never to allow them to remain impacted, even though at first they may not produce serious symptoms! Disregard of that rule leads, frequently enough, to serious consequences. In the nose small foreign bodies, which at first caused no discomfort whatever, have been often found to have served as nuclei for rhinoliths, which not only were the cause of chronic foetid discharge, but the ultimate removal of which presented considerable difficulties. From the pharynx pointed foreign bodies, the immediate removal of which was neglected because they caused no urgent symptoms, have found their way into the tissues of the neck or into the thorax, and have caused fatal hæmorrhage by arrosion of large vessels. In the larynx foreign bodies, when left alone, may either cause perichondritis and lasting disablement of the

larynx, or may become dislodged and fall into the lower air passages, where they may cause trouble of the most serious description. I have seen examples of almost all these contingencies, all caused by neglect in the first instance.

Malignant Disease of the Larynx.

Equally great, as in the class of affections just named, is the necessity of early and energetic local interference in malignant disease of the larynx. It has been conclusively shown that in a good many of those cases in which the disease begins in the interior of the larynx, more particularly on the vocal cords, it can be lastingly cured by so simple and comparatively non-dangerous an operation as thyrotomy with removal of the affected area and a zone of healthy tissue around it, provided only that the diagnosis be made sufficiently early for the affection to be still limited and circumscribed in character. Unfortunately, however, in spite of all that has been said and written, particularly in this country, as to the trivial character of the initial signs in these cases, which usually are objectively represented by the one symptom, obstinate hoarseness, and though it has been frequently pointed out, over and over again, that obstinate hoarseness in a middle-aged person peremptorily demanded a laryngoscopic examination, not a few cases still come under observation, in which the history of the commencement of the illness points to a favourable chance having once existed, but in which no laryngoscopic examination was made in the earlier

stages, and in which so much precious time was lost by useless internal medication, changes of air, and similar measures, that when the patient is at last seen by an expert, the latter finds that the chance has been either entirely lost, or that a much more formidable and maiming operation was now required than had been originally necessary, in addition to which the probability of recurrence was now infinitely greater than it had been at the beginning of the disease. Such cases are so sad, and the responsibility of those who disregard the small beginnings is so heavy, that I would again earnestly plead, as I have done more than once before, for earlier recognition and adoption of the necessary energetic local measures in suitable cases of malignant disease of the larynx.

It is really time that the profession should shake off the unfortunate fatalistic belief in the incurability of cancer, which still holds the public and paralyses all healthy progress in combating that scourge! As matters stand at present, it is not too much to say that the public actually fight against a more hopeful view, and against the most convincing operative results. If, in a case that had been operated upon, recurrence should unfortunately take place, one hears at once the chorus: "Of course, cancer always returns." If, however, the patient, in spite of all croaking and dissuading from operation which forms the common characteristic of patients' "friends," remains well ever after, one hears equally frequently: "But was it really cancer?" or even what has, at any rate, the merit of settling the matter to the speaker's own satisfaction: "It cannot have been

cancer." Such being the general attitude, it is, I hold, the duty of the profession to educate the public towards a better understanding ; to teach them that not all forms of cancer are equally malignant ; that there is an enormous difference regarding the chances of operation in cancers of different parts ; and that, if cancers of certain parts be recognised sufficiently early, whilst the mischief is still purely local, and if they then be at once thoroughly removed, the chances of a lasting cure are very good indeed.

Mistaken Over-zeal.

But whilst thus warmly pleading the cause of local treatment in diseases of the upper air passages where it is really needed, I have no word of defence for the notion which, I am afraid, is very prevalent nowadays, that the discovery, often enough accidental, of the slightest deviation from the normal—or what the observer may be pleased to consider as a deviation from the normal—should be immediately pounced upon as a signal for local interference, and should be visited by some operation or other. Not every little crest or spur of the nasal septum requires the saw, the chisel, or the trephine, not every little puffiness of the mucous membrane over the turbinated bones the galvano-cautery, or the snare. No immediate radical operation is necessarily indicated when a drop of pus is seen in the middle meatus of the nose, nor has the turbinotome to come into play each time the posterior ends of the lower turbinated bones appear a little fuller and more

rounded than they usually are. Not every little bunch of adenoid tissue by chance discovered in the vault of the pharynx must needs be removed, nor ought every tonsil to be cut which slightly projects beyond the palatal arches. Not every granulation or every visible vein at the posterior wall of the pharynx demand the application of the galvano-cautery, nor must the uvula inevitably be clipped because to the man who considers it his duty to "do something" it appears to be a little longer than he would like to see it. No long course of astringent applications is peremptorily indicated when the vocal cords appear slightly pinkish in the case of a professional voice user, and not every singer's nodule demands operative treatment.

I know well enough that such views are diametrically opposed to that teaching according to which every abnormality should be set right, lest it should ultimately cause mischief of some kind. But whilst fully admitting that prevention is better than cure, I do not hesitate to say that one may go too far, even in the laudable intention to prevent mischief; that life is quite endurable, nay, even enjoyable, though one should be the possessor of a small spur in the nose, or of some granulations in the throat, and that I honestly believe that local tinkering of the kind just described is equally little in the interest of the patient and in the interest of the good name of our profession. Yet this is what I am afraid is going on at present on a large scale, and of which one not only hears on all sides, but actually sees but too many examples. Let me give you but one illustration which quite recently occurred in my own

practice. A young lady, recently married, nervous, excitable, and anæmic, complained of choking sensations in her throat, and of a desire to "swallow empty." She consulted a specialist, who found nothing to account for these sensations, but discovered in the vault of the pharynx a little adenoid tissue which, to his thinking, was larger than it ought to be. On examining her ears, he thought the tympana were somewhat retracted. On the strength of the result of this examination he advised the lady to have the adenoids removed, "as otherwise she might become deaf in both ears in six months." Yet this lady had never been deaf in her life, there was no deafness in her family, and she had never suffered from any symptoms referable to the existence of adenoids. The patient was of course greatly frightened, and a consultation was arranged between the first medical adviser and myself. I did not see the least reason for any operation, as I found no more adenoid tissue than one sees in large numbers of perfectly healthy individuals, and as the lady's hearing power was absolutely normal. The first adviser himself admitted that on that day there was no inward drawing of the drum membranes. As I considered the sensations complained of to be of the nature of simple paræsthesia due to her anæmia, we agreed to send the patient, before any operation was undertaken, abroad to take iron waters and baths. She returned perfectly well.—In the course of the consultation, when the decision had been arrived at that no operation should take place at once, I asked the first adviser in private whether he had expected that the removal of the adenoid

tissue would cure the sensations which originally had brought the patient to him. He admitted that he had not thought it would. Here, then, gentlemen, you have a case in which the patient seeks relief for a certain definite complaint. Nothing is suggested to relieve this complaint, but an operation is proposed to avoid an extremely unlikely, not to say imaginary, contingency, and the patient's nerves receive a considerable shock.

*How far is Reference to Possible Contingencies
Permissible and Desirable?*

I should at this juncture like to make two observations which, though interrupting, perhaps, for a moment my chain of argument, ought not, I think, to be left out of consideration in a lecture of this character. The first refers to a lesson to be learned in connection with the case just narrated. I have the distinct impression, from what I hear and see, that it becomes more and more the fashion to frighten—perhaps unintentionally—patients by informing them of all possible contingencies that might happen if the operative procedure upon which the adviser has set his heart were not undertaken. Now I think that such information should be given very sparingly, not wholesale, and that the adviser should carefully discriminate, where it is in the right place and where not. I am far from condemning the practice altogether. Often enough it is not only the right, but the duty, of the practitioner, to warn the patient to beware of the future. Take for instance the case of a middle-

aged man who comes to consult you for hoarseness. He makes very light of the complaint. You detect a suspicious-looking growth on one of his vocal cords, but it is quite impossible to make out at once definitely whether it is malignant or not. You tell the patient—without, of course, mentioning anything of your suspicion—that you must see him again in a few weeks. He demurs to this, and seems altogether inclined to consider you a little fussy. Well, in such a case, in which the question of the diagnosis being established in time is everything, I think it is your duty to hint as delicately as you can, and always avoiding, unless you are driven to it, the dreaded word “cancer,” that more serious developments were not impossible, and that in his own interest the patient ought not to let slip his chances. Usually the handling of these cases is extremely difficult, and no general rule can be laid down for them. The quality, which one patient will praise as frankness, and for which he will thank you, will be condemned by the other—more probably perhaps by his friends—as brutality, and, particularly if, after all, your fears should turn out to have been unjustified, you will forever be decried by that patient’s family and friends as an “alarmist.” Still, in such a case, when you see that a patient may lose his only chance from ignorance of possible developments, I hold it is your plain duty not to let him do so.—Or, to give you another example of more frequent occurrence: Suppose a mother brought you a child suffering from well-marked adenoid vegetations with a history of more or less permanent deafness, aggravated periodically during colds, and accompanied at such times

by violent earache and purulent discharge from the ears. Suppose, further, as so often actually happens, that she began the consultation by expressing a strong hope that you would not recommend an operation. Well, in such a case, it will be simply your duty, I think, when explaining the reasons why, contrary to her wish, an operation should be performed, to emphasise the great danger of lasting and serious impairment of the child's hearing if matters be left alone. But such a warning, I hold, is an altogether different thing from frightening, as in the case just narrated, a patient who comes to you for some quite different complaint, who has never suffered from symptoms traceable to adenoids, particularly not from deafness, and who has long passed the age at which adenoids according to universal experience may exercise unfavourable influences, by the threat of deafness, if by accident you discover an insignificant amount of adenoid tissue in the vault of the pharynx.— Similarly, the threat of deafness seems to me inadmissible, if a patient who never in his life has complained of his nose is found to breathe a little less well through one nostril than through the other, owing to some trifling irregularity in the configuration of his nose; and again, I think it is very undesirable to frighten a patient with the threat of brain complications in an ordinary case of ethmoidal suppuration.

In close connection with the point just discussed is the second one to which I wish to draw your attention. Let me advise you not to hurry patients into operations you may have to recommend, unless there be most cogent reasons for hurry. That cases occasionally occur

which do not brook a moment's delay I am far from denying. I have a few times had patients in my consulting-room with such dyspnœa, that it was touch and go whether tracheotomy might not have to be performed there and then. On more than one occasion have I at a first interview opened retropharyngeal or peritonsillar abscesses, removed foreign bodies from the upper air passages or from the œsophagus, plugged the nostrils in cases of uncontrollable epistaxis, scarified the laryngeal mucous membrane for acute œdema threatening asphyxia, and performed similar urgent operations. In such cases delay, I need not say, would mean dereliction of duty, and further, if the topical application should be of so trivial a character as not to deserve the name of an operation, I see no objection to its being made at once, if at all required, in order to spare the patient a needless repetition of his visit. Thus everybody, I dare say, will apply if necessary the electric current, or the galvano-cautery, or an astringent, on the occasion of a first consultation. But these cases are altogether different from those in which over-zealous operators not merely magnify insignificant affections into most serious diseases, and discover reasons for immediate operation which are unfathomable to other observers, but give the frightened patient no time for consideration, and either perform the operation there and then or in one of their surgical homes within a few hours from the first consultation. Several well-authenticated instances of that deplorable practice have come under my own notice.

Adenoid Vegetations.

I have left until the end of this division of my subject the discussion of local treatment in an affection which only a few years ago appeared to have been so completely threshed out from all possible points of view that nothing more could be said of it, but which quite recently has been undergoing so curious a development that it becomes an urgent necessity to again enter more fully upon it. I speak of adenoid vegetations in the vault of the pharynx. The history of that affection in England has been very remarkable, and well illustrates the vicissitudes of medical fashion referred to in the introduction to this lecture.

Although Wilhelm Meyer's paper on the subject was read before the Royal Medical and Chirurgical Society as far back as 1870, it is no exaggeration to say that the subject up to about 1880 was practically unknown to the profession at large in this country. I well remember that in 1881 I proposed removal of adenoids in the case of the daughter of a personal friend of mine, and the father was so startled by the suggestion of so unheard-of an operation, that before consenting he wished for a consultation with one of the leading physicians of that time. I of course agreed, and the consultation was opened by my consultant asking me: "I say, Semon, what are these things?" That was in 1881!—For several years after that date the operation practically remained in the hands of a few specialists, and it was during that time that one frequently heard

unkind remarks about the specialists having invented a new disease. The benefits, however, accruing from the performance of the operation, in really suitable cases, were too obvious to be overlooked or killed by ridicule. The operation slowly came to be practised in the general hospitals, its originally rather crude technique was much improved by the invention of Gottstein's curette, and by the introduction of anæsthetics into its performance. The original detractors became not merely silent, but not a few were changed into enthusiastic converts, and about 1890 the shortly before despised operation became the rage of the day. Everybody performed it, everybody gave the anæsthetic, the originally limited indications were rapidly extended, particularly when "reflex neuroses"—of which more anon—became fashionable, and ultimately it seemed as if every child required an operation for adenoids. "Have your children already been 'done'?" was—and in some places even now is—the elegant question put by one anxious mother to another at fashionable afternoon teas. When a child caught a little cold, and snored for a night or two, the mother or governess themselves diagnosed adenoids, or, as they preferentially called them, "aneroids." When a boy brought home a bad report from school, the cause must have been adenoids; when a child suffered from asthma, stammering, enuresis, epilepsy, laryngeal papillomata, and what not—adenoids again! In fact, "when in doubt, say adenoids," appeared to become a maxim of contemporaneous pediatrics!

But the hardly-won popularity was not to remain long uncontested. It was about 1891 or 1892 that I

first had the question—which nowadays forms one of the stock ingredients of all these consultations—put to me by an anxious mother, whom I advised to have her child's adenoids removed: "But don't they always grow again?" I well remember how surprised I was at that notion, which at that time I considered extremely curious. Gradually, however, the ever-increasing frequency of the question, and the fact that more and more often children were brought to one, whose post-nasal spaces, although they had been only recently operated upon, were as obstructed by adenoids as if nothing had ever been done, taught one, that recurrences now occurred with a frequency never heard of in the old days, and that the parents' questions concerning them were much more justified than they had seemed at first. Soon afterwards sinister rumours spread as to fatal results which had in various instances attended the operation. They at first received little credence, but when in 1896 statistics were published showing that between the commencement of 1893 and April, 1895, that is, in two years and a quarter, no fewer than eleven deaths had been actually reported in England alone as having occurred in operations performed under chloroform for adenoids and tonsils, general alarm was felt. Chloroform as an anæsthetic in these cases was considered unsafe by many. Anæsthetics having a shorter lasting effect, such as ether and nitrous oxide, were resorted to, and it became an ambition to perform the operation in the minimum of time. It was boasted that it could be done in forty-five seconds, and as late as 1899 a professional anæsthetist referred in a discussion

on the choice of an anæsthetic to operations for adenoids, which occupied "a few seconds, or perhaps half a minute," in their performance. Thus everything gradually combined to damage the prestige of the operation—wholesale performances in cases in which, to say the least, it was not needed; faulty, or at least extremely hypothetical, indications; in but too many instances, technically insufficient execution; a dread of chloroform as an anæsthetic during its performance; and a widespread reputation of recurrences. The natural result of all this was bitter disappointment on the part of many parents who had reluctantly given their consent to the operation on the strength of glowing promises concerning improvement in the general health, and disappearance of all possible troublesome symptoms in remote parts of the child's body which would certainly follow its performance, and who saw none of these promises realised. A paper recently published by a lady in one of the monthly reviews depicts graphically enough what is felt in large lay circles about the whole question.

But already previous to its appearance the unavoidable reaction had occurred in the profession itself. Mr. Arbuthnot Lane took up the cudgels against the massacre of the innocents in two papers published in 1896 and in 1899. In the first he declared that operative procedures were, in his opinion and experience, "quite unnecessary," and that "systematic ventilation of the lungs and naso-pharynx provided us with a means not only of applying to the naso-pharynx such force as is exerted by air being forcibly drawn through

it, but by oxygenating the blood more fully and removing more thoroughly the carbonic acid, etc." All these desirable results were to be obtained by systematic "breathing exercises," in poorer cases a printed slip being given to parents containing the following simple instructions: "Put the child on its back three times a day for half an hour at the time, and make it breathe in and out as deeply as possible through the nose, the mouth being kept shut." The second paper brought important modifications of these sweeping statements. Whilst in 1896 the author had declared that operative procedures were "quite unnecessary," and that, "unfortunately for the patients, surgeons under the influence of the suggestion of Wilhelm Meyer had considered that the secondary infection of the so-called pharyngeal tonsil was the primary cause of the obstruction of the naso-pharynx, and had hoped to cure the patients by cutting away a varying portion of the substance," he was good enough to admit in 1899 that after all there was a "very small proportion" of cases in which the operation was required in order to "establish a through way" or to "telescope the duration of treatment." He says in conclusion:—"The only circumstances under which I can understand the surgeon being warranted in attacking the pharyngeal tonsil are: (1) When the condition has been so thoroughly neglected that the child is unable to drive air through the naso-pharynx, when development has been long in abeyance until the enlarged pharyngeal tonsil has been effectually removed; (2) when for some reason or another, such as considerable difficulty in forcing air through the

nose, ear trouble, important school or other arrangements, peculiar circumstances, etc., it is necessary or desirable to telescope the duration of treatment; and (3) when the child is too young to do what it is told."

I think it is a very great pity indeed that Mr. Arbuthnot Lane should not have stated in his first paper the indications admitted in his second, which "warrant the surgeon in telescoping the duration of the treatment." Had he done so, it would have been seen, I feel sure, that, apart from his absolutely unproven theoretical ideas as to the origin of adenoids, the difference which separated him from the moderate section of his surgical *confrères* was not one of kind, but only of degree. For this moderate section also advises operation in such cases only as he admits as legitimate in the concluding sentences of his second paper, and so far as matters of fact are concerned, the only real point of contention between him and them is this, that the cases in which operation should be performed, in his experience, constitute "a very small proportion only" of the whole number, whilst they find that the very circumstances enumerated by him—long-standing neglect, very considerable obstruction, deficient development, ear troubles, important school or other arrangements, "peculiar circumstances," young age of the patients—are met with considerably more frequently than in "a very small proportion only."

Meanwhile, however, the wholesale condemnation of the operation in his first paper, and particularly the

suggestion of the "breathing exercises," had caught on. Society, ever on the outlook for some novel sensation, is as fond of changing its medical fashions as any other. Yesterday it was the bone-setter, the marvellous voice-producer, a new method of dieting, hygienic under-clothing of some particular kind, antipyrin, massage, thyroid tabloids, anti-fat, *et hoc genus omne*, that were the rage of the town; to-day it is some new medical genius—"a perfect wonder, my dear,"—just discovered by a leader of society or a prima donna; the Kneipp cure, or its degenerate progeny, the sandal craze; Christian Science, rheumatism rings, a new brand of Moselle, electric light baths, that are in everybody's mouths. What it will be to-morrow nobody knows; it is characteristic of Society's rages that they almost always have a very ephemeral existence. Thus with the adenoid mania: The question, "Have your children already been 'done'?" was really becoming a little stale; fresh fields and pastures new were wanted; the difficulty was only to find something original that would suitably replace the old fashion. At last the revelation came—breathing exercises! "I thank thee for that word" must have been the thought of many a professor of calisthenics, massage, gymnastics, and corpulence curer with a keen eye to business, who perceived that here a new and promising opening offered itself. No sooner said than done: departments for "breathing exercises" were opened, the public flocked to them in their thousands, a roaring trade was and is being done at this moment, and children galore, who otherwise would have been

operated upon by the doctors, are now, if reports be true, cured or enormously improved by so simple a means as breathing exercises.

But are they?

Well, gentlemen, I may be an incurable sceptic, but I have no hesitation in telling you that I do not believe for a moment that a single child that has got well-marked adenoids has been, or ever will be, cured by breathing exercises, all reports to the contrary notwithstanding. I mean no disrespect to Mr. Arbuthnot Lane, but I cannot help saying that the whole idea seems to me preposterous. Whether adenoids be secondary to "infection of the nasal mucosa" or not, there can, at any rate, be no doubt that they obstruct in well-marked cases the airway, and thereby most efficiently prevent that ventilation of the lungs which, according to Mr. Lane himself—and, may I add, according to every reasonable observer before him who has worked at the subject—is of such enormous importance. It logically follows that the obstruction, whether primary or secondary, must be got rid of as a first step towards enabling the patient to breathe freely and to ventilate his lungs. This surgeons have hitherto done—and no doubt will continue to do—by "telescoping the treatment," or, in other words, removing the obstruction in the quickest and most complete way—that is, by operation—just as they would do under analogous circumstances in any other part of the body. But, according to Mr. Lane, this is, with a very few exceptions, "unnecessary, imperfect, and unscientific," since it deals only with an effect, and not with the primary source of

infection. In view of the many thousands of cases, which beyond the shadow of a doubt have been cured by the unnecessary, imperfect, and unscientific treatment—and, mark you, by this treatment alone—which Mr. Lane condemns, it certainly demands some courage to make such a statement. His adversaries, however “unscientific” they may be, certainly have facts on their side. And if it should be called “unscientific” to say plainly that the *rationale* of his treatment was a mystery to them, I for one must plead guilty to that soft impeachment. How a genuine lymphoid hypertrophy can ever be expected to be dispersed by “breathing exercises” completely passes my understanding. Is it by the air being forcibly drawn over it? If that were possible, will Mr. Lane explain how it is that in so many cases of much-developed adenoids there are at the same time much-enlarged tonsils? It would seem to me that if forcible breathing could disperse lymphoid tissue in those cases in which nasal breathing is reduced to a minimum, and in which the patients have thus been compelled to forcibly breathe, not for half an hour three times a day, but all days and all nights for many months or even years, the effect of the forcible passage of air ought certainly to show itself in the disappearance of the enlarged faucial tonsils, which in structure are so very similar to adenoids. But, unfortunately for Mr. Lane’s theory, these do not disappear; on the contrary, they flourish!—On what grounds, then, are “breathing exercises” expected to act beneficially in cases of genuine hypertrophy? Are they to do wonders by imparting “force” to the naso-pharynx; or is it

thought that half an hour's "oxygenation" of the blood three times a day in twenty-four hours will in such a miraculous way alter the constitution as to make the actual obstruction of the air passages disappear? I fail to discover other arguments in Mr. Lane's papers, and I hope he will not be too indignant with me if I frankly state that his "breathing exercises" appear to me simply in the light of a scientific glorification of the obsolete advice referred to in the introduction of this lecture, and so freely administered to the unfortunate sufferers before Wilhelm Meyer's beneficent discovery, "Keep your mouth shut. Shut your mouth."

Not that I despise breathing exercises in their proper place. On the contrary, for many years before Mr. Lane ever gave public utterance to his ideas, I, like, I dare say, most operators, have been in the habit of telling mothers that after the removal of the obstruction, they must insist on the child's learning to breathe through the natural air channel—namely, through the nose; and that if admonition alone failed to cure the habit of mouth breathing, engendered by months' or years' impossibility of breathing through the nose, they must use for some time some simple contrivance which covered the child's mouth completely, and compelled it to breathe through the nose. An apparatus of that sort was recommended many, many years ago by Professor Guye, of Amsterdam, under the name of "contra-respirator." It is nothing else but an anticipation of Mr. Lane's leading idea, the only difference being, in my humble opinion, that it brings in "breathing exercises" in their proper place, whilst Mr. Lane, if he

will excuse me for saying so, seems to me to put the cart before the horse.

Now, I shall probably be told that all my theoretical objections go for very little in view of the fact that the patients were cured by the breathing exercises. But, I repeat, is it a fact? I do not believe it. Not that I doubt the good faith of those who think that they have seen cures, but I feel convinced that in such cases transitory congestion of the lymphoid tissue in the vault of the pharynx has been mistaken for actual hypertrophy. In such cases I can easily enough imagine what has happened. The lymphoid tissue, being very vascular, easily becomes the seat of catarrhal inflammation, when it swells considerably, and *pro tem.* may present all the symptoms of genuine adenoids. Now, suppose that a child was taken during such an attack to a medical man because the mother wished him to see the patient "at his worst," a casual examination might easily enough result in the verdict "adenoids," and in the advice "operation." The mother, dreading operation, decides that a trial should first be given to the "breathing exercises" of which she has heard so much of late. The child is put through a course which lasts several weeks, if not months, and all the symptoms disappear. That exactly the same result would have been obtained if the child had simply been taken a little care of, but otherwise been left alone, does not, of course, enter for one moment into the consideration of the happy mother (and how could it?). Lavish praise is heaped upon the breathing exercises to which alone the credit of the

recovery is given ; and the doctor is severely blamed for having recommended a perfectly unnecessary operation. Considering the frequency of these inflammatory attacks, and the readiness with which nowadays the advice to remove adenoids is given, the number of such cases, in all probability, is very considerable, and it is easily enough intelligible that they should have lent colour to a perfectly honest belief in the efficiency of breathing exercises. But beliefs are not facts, and how little the actual facts agree with Mr. Lane's teaching the following case, which recently occurred in my own practice, will show you.

A little girl had suffered for a long time from well-marked obstruction of the naso-pharynx, mouth-breathing, thick voice, snoring at night, commencing pigeon breast, tendency to colds, earache, anæmia, and weak state of general health. At the suggestion of the family doctor she was taken to a distinguished surgeon, who diagnosed, as the family doctor had already done, adenoids, and recommended their removal. The parents being much averse to operation, took the opinion of another authority, who advised breathing exercises. The child was placed under a professor of Swedish gymnastics, who makes, I am told, a speciality of such exercises, and for two months assiduously went through a course. Meanwhile, the parents flattered themselves that they observed considerable improvement in the child's symptoms, whilst the family doctor was unable to perceive it. Whilst still under the treatment the child caught pneumonia and nearly died. During the acute disease her respiratory difficulty was so

obviously increased by the impossibility of breathing through the nose that the family adviser insisted that after her convalescence yet another opinion should be taken. I was consulted, and found the naso-pharynx crammed full of adenoids. Remember, this child had been treated for two months with breathing exercises ! I, of course, warmly supported the family doctor's and the first consultant's advice ; the parents at last consented. The child was operated upon by the surgeon first consulted, who found, he told me afterwards, the nasopharyngeal cavity, as I had found it, crammed full of genuine adenoids, and who added that he had quite recently received a letter from the father, warmly thanking him for the genuine improvement which since the operation had taken place in the child's local symptoms and general health.

It did not require the lesson taught by this case to convince me of the untenability of Mr. Lane's teaching, but it is valuable as showing that practical experience, no less strongly than theoretical considerations, militates against what I am afraid I must call an exaggeration in the ultra-conservative direction.

But whilst thus defending Wilhelm Meyer's beneficent discovery against the onslaught of a solitary adversary, I am at least equally anxious to save it from the much more dangerous indiscretion of its injudicious friends. There is not the least doubt in my mind, from what comes under my personal observation, that a great amount of over-operation of a slipshod nature is going on with regard to adenoids, and if we wish to prevent a good operation from falling into bad repute, it seems to

me necessary to come to a much more precise understanding, as to the conditions under which operative interference should be recommended and how it should be carried out, than exists at present.

I would deduce the following principles as helpful :—

With regard to the question of operation, adenoids may fitly be subdivided into three classes, according to whether they cause : (*a*) permanent, (*b*) periodical and transitory, (*c*) no symptoms.

The first class, the “typical adenoids,” embraces the cases in which respiratory obstruction, open mouth, snoring, thick voice, deafness, are all, or some of them, always present, and in which the altered type of respiration may have already led to the peculiar deformities of the face and chest, and to a general debilitated state of health. In this class—in my experience a very large one—I consider operation absolutely indicated, and I advise it the more strongly the further away the child is from the period of puberty, at which, often enough, though by no means always, spontaneous atrophy of the growths occurs. For even if the condition should never become complicated, as it so often is in these cases, by inflammatory ear affections, or by one or another of the febrile diseases of childhood, the mere alteration of the natural type of breathing and the deficient aëration of the lungs will, if unrelieved for years, leave their ineffaceable traces in the physiognomy, physique, and entire mental and bodily development of the patients. Seeing that all these serious consequences of the obstruction of the air-way and hearing channels can be prevented by so simple and comparatively safe an

operation as the removal of adenoid vegetations, I hold it to be the practitioner's bounden duty strongly to urge operation in this category of cases. It is the one which has established the well-deserved fair fame of the operation, the result of which under such circumstances is always very gratifying, and often truly astounding.—In exceptional cases this applies also to the removal of adenoids in adults, but such cases are, in my experience, extremely rare.

Much more difficult is the question of operation in the second class, in which free intervals alternate with periods of nasal obstruction and impairment of hearing, or attacks of earache, and even of otitis media. This is the category previously referred to, in which during the free intervals only a very moderate, or hardly any, organised hypertrophy of the lymphoid tissue may be present, but in which on the slightest catarrhal provocation so much congestion and engorgement occurs, that for the time all the symptoms of the first class—the genuine adenoids—are closely simulated. It may well be that opinions with regard to the advisability of operation in one and the same case belonging to this class should diametrically differ according to the period at which the little patient is seen. A. sees him “at his worst,” a mouth-breather, snuffling, with thick voice, very deaf, and with some otorrhœa, and strongly advises operation. B. sees him a few weeks later, when the acute attack has passed off and all these symptoms have temporarily disappeared, and cannot understand why A. should have recommended operation.

I may observe here that I am afraid that, owing to

our great familiarity with the affection, some of us pay insufficient attention to the—often enough rather emphatic—statements of the parents, governesses, or nurses as to the periodicity of the symptoms. This, however, is a very important point. It is just this class of cases in which the most experienced may make mistakes. Suppose he urges strongly that the operation should be performed as a prophylactic measure, suppose that the advice is not followed, and that nothing serious occurs, he is certain to be put down by the parents as an alarmist and fanatical operator. Should the child meanwhile have gone through a course of “breathing exercises,” it is they which get the kudos of the improvement. Suppose, on the other hand, that, guided by the desire to spare the child a possibly unnecessary operation, one votes against operation, or, at any rate, in favour of postponement, and that unfortunately shortly afterwards acute ear complications should arise, or an abscess form in one of the lymphatic glands or pulmonary troubles occur, to which these patients seem rather prone—one is equally severely blamed for not having spoken more strongly in favour of an operation which might have obviated all these deplorable and sometimes lasting consequences. What I would recommend under these circumstances, although no formula will fit all cases, and occasional errors of judgment are almost unavoidable, is this: If a child be brought to you “at his worst,” but with a definite statement that these attacks occurred only very rarely, that they lasted but a short time, and that in the intervals the child enjoyed perfect

health ; if you find some soft swelling of the lymphoid tissue in the vault of the larynx, but no evidence of organic ear disease ; and if altogether you gain the impression that the child had been brought much more because the mother was anxious than because there were any really urgent symptoms, express a desire to see the child again under, what would be for it, normal circumstances, and postpone the decision with regard to operation until then. If the symptoms be more grave, particularly if there should be marked deafness, perforation of the tympana, otorrhœa, enlargement of the lymphatic glands in the neck, a tuberculous family history, vote in favour of operation as a preventive of more serious events, which, in view of the circumstances named, might reasonably be expected. If you are in doubt yourself—as in these “half-way house” cases the most experienced observer often enough is—let me recommend you to lay as clear and non-alarming a statement as possible of the actual conditions and of the various possibilities of development before the parents, and let them decide themselves. This course will equally protect you against being called an “alarmist” and “very fond of operations” on the one hand, and against being accused of having “neglected” the case on the other.

Concerning the third class, I have only to repeat what I have said in the earlier part of this lecture, namely, that adenoids which do not cause any symptoms do not, in my opinion, require removal. One often enough in the course of a methodical examination of the upper air passages discovers a not inconsiderable amount of lymph-

oid tissue in the vault of the pharynx, which evidently has never done any harm, just as one often enough sees somewhat enlarged faucial tonsils which have never given rise to the least inconvenience. Such innocent hypertrophies should, I feel sure, be left alone, particularly in adults, and all the examiner might tell the patient, in order to safeguard himself against an imputation that he had "overlooked" the condition, is, that there was a slight fulness, but that this, unless it should cause any symptoms, did not require operation.

These are the suggestions which I have to make with regard to the indications for operation. You will probably be surprised that amongst them I have not mentioned, by one single word, the so-called "reflex neuroses" for which they are so frequently undertaken. Well, gentlemen, in my second lecture you will hear that I am a great sceptic with regard to "reflex neuroses" arising from the upper air passages in general, and I will say at once that I am particularly so with regard to reflex neuroses said to be due to adenoids. I am not in the habit of doubting the reports of others simply because I have had no analogous experiences, and I have already told you, as was my duty, that obscure affections of the most different kinds have been attributed to adenoids, and are stated to have been cured by their removal. Personally, however, I must say that I have never performed any operation for adenoids for the express purpose of curing one of these reflex neuroses, though I need hardly tell you that in the course of the last twenty years plenty of these cases have come under my notice. In such of these

cases in which I found an insignificant amount of adenoid tissue and none of the classical symptoms accompanying it, I have not been able to bring myself to the belief that asthma, epilepsy, enuresis, and similar neuroses, which had been ascribed to the adenoids, were really due to them, and I have therefore not seen my way to advise operation. But in cases in which, besides the reflex neuroses ascribed to them, the adenoids caused actual tangible respiratory and auditory symptoms—and I have seen a good many of such cases too—I have operated, always thoroughly explaining to the parents beforehand, in order to avoid disappointment, that I advised operation only for the sake of removing the obstruction which interfered with breathing, hearing, and general development, and that I could give no promise whatever as to the cure of the reflex neurosis. That caution in my practice has turned out to have been a very judicious one, for in not one single case have I ever seen a so-called reflex neurosis disappear after removal of adenoids in such a manner that I could rightly have spoken of a causal relation between the two. True, in a few cases I heard long afterwards that asthma, enuresis, epilepsy, etc., from which little patients of mine had suffered at the time of the operation had disappeared, or at any rate diminished; but then it is well known that these neuroses often enough improve spontaneously, and in all my cases the interval between the operation and the commencement of the improvement had been much too long to justify me in attributing the improvement to the operation itself, or to its influence upon the general health. On the other

hand, I know positively of not a few of my own cases in which, though the general health had been materially improved and the direct symptoms due to the adenoids completely disappeared, the reflex neuroses persisted for many years afterwards with undiminished intensity. Only quite recently I saw a boy of nine, who six years ago was sent to me for most troublesome salivation, said to be due to adenoids. Adenoids there were, certainly, and in such quantities as to seriously interfere with the child's breathing and general development; but why they should cause the salivation was more than I could understand without taking refuge in most artificial theories. I advised and performed the operation for the general reasons just named, but I strongly warned the mother that I could not in the least promise disappearance of the salivation. When I saw my little patient a few weeks ago, he had developed into a very fine strong boy, but the ptyalism was just as unpleasantly there as it had been six years ago. Similar things I have seen in connection with asthma, stuttering, stammering, enuresis, epilepsy. Experiences of this kind fully warrant me, I think, in strongly advising you not to be too sanguine with regard to the connection of adenoids and reflex neuroses. To promise positively a cure of the latter if only the adenoids be removed, as I know has been but too often done, I consider simply unwarrantable.

Finally, in this connection let me warn you, as others have already done before me, against too hastily diagnosing adenoids from facial appearance and nasal obstruction alone. Although the "adenoid face" in a

fully-developed case is characteristic enough, deformities of the nose itself and of the hard palate, as well as enlargement of the posterior ends of the lower turbinated bones, may closely simulate the symptoms produced by adenoids, and it ought to be an invariable rule, therefore, to decide for operation on the strength of thorough examination only—a rule which, I am afraid, is not always adhered to. As to the examination itself, in a good many cases, particularly in elder children and in adults, posterior rhinoscopy will suffice, without the unpleasant investigation by the finger being resorted to. In all cases, however, in which there is the least doubt, I strongly advise you to employ digital exploration, which in these cases, I do not hesitate to say, is greatly superior to mere inspection, inasmuch as it gives you much more reliable information about the quantity of growths present than is afforded by the rhinoscopic mirror.

So far as the operation itself is concerned, I would impress you with one principle: Operate thoroughly!—I have not the least wish to lay down dogmatic rules as to the technique of the operation, although I hold very strong opinions on that point as well. But, whatever method you may employ, operate thoroughly, gentlemen, and never forget that the question is not whether the child is forty-two seconds and a half or five minutes under the anæsthetic, provided that the latter be administered, as in these cases it always ought to be, by a competent anæsthetist, but whether there is to be a recurrence or not.

Next to over-operation, I have no hesitation in saying

that nothing has so much damaged the reputation of the operation as the frequency of so-called "recurrences" observed of late years. No doubt, perfectly genuine recurrences will occasionally take place, even after very thorough operations ; but such an event is, in my own experience as well as in that of all thorough operators with whom I have discussed that question, very rare indeed, and I have not the least doubt that what is commonly called a "recurrence" is in the enormous majority of cases in reality "incomplete operation." One must have seen such cases shortly after operation in order to be enabled to judge in what an incredibly slipshod manner the operation is nowadays but too often done, and how the cry "recurrence" has come to be raised. A whiff of gas, a little scraping with the fingernail, and behold ! the "operation" has been performed, and the parents are left in the belief that all has been done that could be done. A few months, nay, even weeks, after the "operation" the old symptoms come on again ; the parents in distress seek another opinion, and, when they are told that the operation has to be performed anew, ask in despair : "But don't they always grow again ?"

Against this class of "recurrences" there is only one safeguard, but it is a very efficient one : thoroughness of operation, and this thoroughness must be preached until it is generally practised. I need hardly say that this thoroughness is not equivalent to violence. Unfortunately, whilst one very frequently meets with instances of under-operation, one occasionally comes across sad examples of the other extreme. I have seen

cases in which the operator had so proceeded that the ugliest adhesions had formed in the naso-pharyngeal cavity and between the soft palate, the pillars of the fauces and the posterior wall of the pharynx—an aspect, in fact, resembling that of cicatrisation in congenital or tertiary syphilis, and in these cases the articulation of the victims was materially and lastingly impaired. That certainly is not the kind of thoroughness I recommend. But the desirable thoroughness I have in view can only be obtained, so far as I can see, by the operator being in the position of not being hurried unduly by the brief duration of the anæsthesia, nor by the fear of any untoward event during the operation itself.

Personally I have not the least doubt that these conditions are most ideally obtained by (*a*) chloroform being selected as an anæsthetic in these cases; and by (*b*) the patient being operated upon in the recumbent position with his head well bent over the back of the operation table. If chloroform be quietly and slowly administered by a competent anæsthetist, and never pushed to the abolition of the cough reflex, it introduces, to the best of my conviction and experience, no amount of danger into the operation, and it gives the operator time to remove the growths thoroughly. If the recumbent position be adopted, with the head well over the table, there is no danger of blood or a loose fragment of adenoids penetrating into the larynx or lower air passages. These—as I consider them—most essential conditions having been secured, the operator can then at his ease thoroughly remove the

growths by whatever instruments he prefers (personally I almost always use the two models of Gottstein's curette, the curved and the straight one, and Hartmann's laterally-cutting curette, whilst in exceptional cases only I employ Woakes's modification of Loewenberg's forceps). The operation ought not to be considered as finished until the operator, by thorough digital exploration, has convinced himself that not a vestige of lymphoid tissue projecting over the surface of the mucous membrane has been left behind. Should the tonsils have to be removed at the same time, I usually remove the adenoids first and the tonsils afterwards. Only when the tonsils are so large that it is impossible to introduce instruments into the nasopharyngeal cavity, without impeding respiration, I remove them first. I have heard my method described as "fussy," but it is safe, and it certainly yields indefinitely fewer recurrences than that of the lightning operator. No after-treatment of any kind is necessary beyond keeping the patient in bed for twenty-four hours, and in the house for two to three more days, an aperient being given the first evening, if there should be a rise of temperature. I warn especially against any "antiseptic" injections being made through the nose. It is many years since I gave them up completely, and I am glad to be able to state that I never since have had an acute ear complication.

Others may prefer other methods. I have not the least wish to assert that the method I recommend is the best, or the only one by which success may be secured, but from long and ample experience I can honestly state

that it answers all reasonable requirements, and if you proceed by it, selecting suitable cases only for operation, you may be confident that you will maintain the prestige of one of the most salutary operations of modern times.

If, in conclusion of this lecture, I were to briefly summarise the advices given in it, I should say this :—In all purely local affections of the upper air passages there are certain cases in which all reasonable men will agree that local treatment is required, and others in which the moderate section at any rate will be unanimous that it is not. Between these two classes there is the very large intermediate one in which everything is a question of “degree,” and in which opinions may legitimately differ as to whether local treatment should be adopted or not. Far be it from me to assert that occasionally mischief may not be done by doing too little, but if I endeavour to judge impartially the current of opinion at the present moment, I have no hesitation in stating that, if at all, we err at the present moment in the opposite direction, and I cannot better sum up the advice which I think should at this juncture be given, than by reminding you of Talleyrand’s celebrated counsel to a young diplomatist who for the first time was sent on an independent and responsible mission : “Above all, not too much zeal !”

LECTURE II.

2. LOCAL MANIFESTATIONS OF GENERAL SYSTEMIC DISEASES.

OF the systemic diseases in which throat and nose complications occur, and which may require local treatment, tuberculosis, syphilis, and affections of the central nervous system are the most important. True, there are many other systemic affections in which the upper air passages may participate. Thus pharynx, larynx, and nose may be severely affected in lupus and leprosy; dry pharyngitis may be a very unpleasant symptom in diabetes; granular pharyngitis is very often found in general anæmia and chlorosis; laryngeal oedema may occasionally be observed in Bright's disease; ulceration and perichondritis of the larynx may occur in typhoid and other acute fevers; influenza may lead to empyema of any of the accessory cavities of the nose, to laryngeal paralysis, and to many other complications affecting the upper air passages; gout, rheumatism, urticaria, pemphigus, actinomycosis, and small-pox may implicate nose, pharynx, and larynx; and this list could easily be extended. But the throat and nose complications in many of the affections just named are rare, and some require no local treatment whatever,

except an occasional palliative ; while in other instances—as in laryngeal stenosis, or in empyema of the antrum due to any of the affections named—they must be treated exactly as if the affection were purely local. Thus there is no need for me to enter specially upon them. Matters, however, are somewhat different in systemic affections belonging to the first group. Here experience has furnished us with certain valuable principles, which, in addition to the individual requirements of each case, ought always to be considered, when the question of local treatment of throat and nose complications arises.

Tuberculosis.

This applies particularly to tuberculosis. I need not speak of the frequency and importance of its laryngeal complications, which but too often, in the complex of symptoms, unfortunately play the *rôle* of the predominant partner, and urgently require relief. A patient suffering from laryngeal tuberculosis, who cannot eat and drink on account of the difficulty and pain accompanying the act of swallowing, will, of course, go more rapidly down hill than he otherwise would do, because he is prevented from assimilating the amount of nourishment indispensable to combat the inroad of the general disease. To tell such an unfortunate person, as was generally done twenty years ago, and as is done, I am afraid, but too frequently now : “Take care of your general health and let your larynx take care of itself,” is to my mind not much better than a cruel mockery, though it is, of course, not

intended as such. Unfortunately he who gives that cheap advice altogether forgets to instruct the patient how he is to take care of his general health when he cannot swallow. Here it is obviously the duty of medical art to step in and help, and the only question is whether this help should be of a purely palliative, or, if possible, of an actively curative, character.

Now this question, simple as it seems, is extremely difficult to answer, and nothing could better illustrate what I have said in my first lecture as to the frequently shifting character of modern therapeutic views than the various answers given to it in the course of the last twenty years.

As recently as 1881 the late Professor Krishaber, of Paris, stated verbatim in the discussion on the pathology of laryngeal phthisis which took place at the International Medical Congress of London, as the result of his long and extensive experience:—"I will not say that tuberculous laryngitis is incurable. I maintain only that the local therapeutic means in use are ineffective, and that they are damaging rather than useful." Although most of the other speakers on that occasion did not take so gloomy a view, yet the general opinion was anything but cheerful with regard to the influence of local measures upon laryngeal tuberculosis. Shortly afterwards, however, Professor Krause, of Berlin, introduced the lactic acid treatment, and this in turn was quickly followed by its combination with scraping of laryngeal tuberculous ulcers. The most enthusiastic advocate of this method was Dr. Heryng, of Warsaw, who for a good many years never

tired of extolling its virtues and demonstrating at medical gatherings patients with "cured" laryngeal tuberculosis, and instructive specimens of completely cicatrised laryngeal ulcers from patients who later on had succumbed to the ravages of the pulmonary disease. The pendulum of public opinion now swung in the exaggeratedly hopeful direction. Any number of "cures" of laryngeal tuberculosis were reported, and more and more energetic surgical measures for its treatment were recommended: deep scarification of the swollen epiglottis and aryteno-epiglottic folds; removal of diseased arytenoid cartilages; thyrotomy and scraping of the whole laryngeal mucous membrane; nay, even removal of the whole larynx—each found its enthusiastic advocates.

In the midst of all this progressively radical surgical treatment the introduction of tuberculin for a short time threatened to supersede it altogether. No better field for observation of the effects of the magic fluid could be desired than the larynx. We all injected, and waited in breathless silence for the healing and the cicatrisation of the laryngeal ulcers. But, alas! our hopes were doomed to disappointment; beyond the fact that the ulcers assumed a somewhat cleaner aspect no curative effect was observed, and within a very few months from the introduction of the treatment, the man, whose eightieth birthday the whole medical world prepares to celebrate this week with great rejoicings, my venerated great teacher, Professor Virchow, added to the countless obligations under which he had laid our science, by showing beyond doubt the dangers of the new method.

As a result of his demonstration, it was, except by a very few faithful adherents, thrown over as suddenly as it had come into fashion, and we all returned to combating the local effects of the disease by local means. But somehow the enthusiasm had cooled down, and during the last few years very little has been heard of the local treatment of laryngeal tuberculosis in comparison with the panegyrics of some ten years ago. On the most recent occasion when the question was discussed—namely, at this year's meeting of the British Medical Association—many speakers related their views and experiences concerning the indications, forms, and results of the local treatment of laryngeal tuberculosis, but no new facts were elicited; and Dr. StClair Thomson—rightly, I think—stated that practically no progress had been made during the last six or seven years, and that the subject was in a very unsatisfactory condition.

The views I have myself formed from personal experience on the question of local treatment in laryngeal tuberculosis are the following:—

In the first place, I think we should as much as possible avoid the word “cure” when speaking of the chances of such treatment, for it is distinctly misleading in this connection. We have to deal with local manifestations of systemic disease, not with a purely local process; and even if we succeed in arresting the particular local manifestations against which our efforts are directed, we cannot, unfortunately, promise our patient that the arrest will be a permanent one, nor that, even if the exact spot in which we have been working should lastingly remain free, quite similar manifestations,

causing similar painful symptoms, may not within a very short time after the end of a really successful treatment break out in the immediate vicinity of that spot. The disappointment under such circumstances is always cruel. Nevertheless, seeing that it is our first duty to give relief if we possibly can, and that there is, at any rate, a fair chance of the result being permanent, we must, of course, have recourse to proper local treatment in suitable cases; but, in view of the uncertainty just named, it will be wise, and may spare the patient and his friends bitter disillusion, not to talk of a "cure," but of relief which we trusted would be more than passing, although that could not be definitely promised.

Secondly, in no disease perhaps is there greater need for individualisation and for treating each case on its own merits than in laryngeal tuberculosis. Simply to identify, as I am afraid is done very often, the presence of that complication with the idea that it must be actively treated with lactic acid, and possibly by curetting, would be a mistake similar to identifying the diagnosis of laryngeal cancer with the idea that thyroto-my must be performed. In both instances routine practice would ultimately and inevitably lead to valuable methods becoming discredited. When deciding whether any, and if so what, form of local treatment should be adopted in laryngeal tuberculosis, everything—the form, the situation, and the extent of the local manifestation—has to be carefully considered. So long as there is merely infiltration with unbroken surface, be this infiltration of a pseudo-œdematous or of an indurative form, I strongly advise in principle to

leave matters alone. I know that some authorities recommend submucous injections of guaiacol, creosote, or perchloride of mercury, etc., and others removal of the tumefied parts by means of curettes, forceps, snares, followed by energetic applications of lactic acid. Of the submucous injections I have no personal experience. Of the surgical measures named, I admit that in some cases the dysphagia is so great that energetic procedures may have to be resorted to. In a case of my own, in which, so far as could be judged, the epiglottis alone was the seat of an enormous tuberculous infiltration, which rendered swallowing practically impossible, whilst there was no evidence of pulmonary disease at all, the whole of the epiglottis was removed after subhyoid pharyngotomy, with temporarily very satisfactory, though unfortunately but transitory, results. A year after the operation both lungs were found to be extensively diseased, and ulceration had occurred in the stump of the epiglottis and in the neighbouring parts of the cicatrix.—But, unless the dysphagia renders drastic measures imperative, I feel sure it is much better in cases of tumefaction without ulceration not artificially to produce a breach of the surface, and I think that the correctness of that advice is being gradually and more generally admitted. If the tumefaction be so considerable as to produce serious laryngeal stenosis, tracheotomy may be indispensable to prevent suffocation, and a few cases have been reported in which the rest given by that operation to the diseased organ appeared to have an actually curative effect upon the laryngeal infiltration. But this is a result which cer-

tainly cannot be expected to follow regularly, and on the whole it will be much better to reserve the operation for urgent cases only.

Should there be already ulceration when the patient comes under observation, the questions of its situation and its extent are of paramount importance. If there be one ulcer, or a few not too large and well-circumscribed, the chances of arresting the local mischief by appropriate local treatment are by no means bad, particularly when the ulcers are situated on the vocal cords, the ventricular bands, or in the interarytenoid fold. Ulcers of the epiglottis, the mucous membrane over the arytenoid cartilages, the aryteno-epiglottidean folds, or in the subglottic cavity, are not nearly so easily accessible to local treatment. Should the ulceration be almost universal, and be accompanied by caries and necrosis of the cartilaginous framework of the larynx or of large parts of it, the curative chances of local treatment are very small indeed.

The local treatment will accordingly have to vary greatly under these different circumstances. In cases belonging to the first category, energetic lactic acid treatment, if necessary, combined with scraping or removal by double curette or cutting forceps of the tuberculous deposits, will sometimes yield very gratifying results. I now look back upon a number of cases of my own thus treated, not large, it is true, but still gratifying enough, in which treatment of this kind has resulted in lasting arrest of the laryngeal mischief. One ought even not to be discouraged if, either in the scar of the hardly-healed ulcer or in its neighbourhood, fresh ulcera-

tion should occur. In a few of my own cases repetition of the treatment—which occasionally had to be resumed several times at longer or shorter intervals—ultimately led to lasting cicatrisation and freedom from pain and dysphagia. But no general rule can, I think, be laid down about such repetitions of the treatment, and I cannot sufficiently emphasise that in this large category every case must be treated according to its individual features.

In cases belonging to the second class the technical difficulties are much greater; the affected parts recede under the touch of instruments, and as a rule the results are less satisfactory than those obtained in the interior proper of the larynx. Still, so long as there is a reasonable chance of arresting the process, I consider it not merely legitimate, but clearly indicated, to try and do so, as it is just in these cases of commencing ulceration of the epiglottis, the mucous membrane over the arytenoids, or the aryteno-epiglottic folds, in which the concomitant pulmonary process may not yet be much advanced, that the patient's chances are most jeopardised by the dysphagia depending upon the laryngeal complication. Should intra-laryngeal measures fail and the dysphagia be excessive, or should a subglottic ulceration spread to the posterior wall of the larynx, external operations may be considered. In a few cases of that kind thyrotomy, followed by thorough scraping and application of pure lactic acid to the seat of the former ulcer, has yielded satisfactory results. In a case of my own thus treated the patient has now, I am glad to say, remained quite well for four years. But the external

wound in these cases is very apt to become infected during the operation, and a second extensive operation may be necessary to remove the infected tissues. This occurred in my own case and in various others that have been reported. Hence, operations of this kind should not be lightly undertaken, and should be reserved for exceptional cases. They may of course be absolutely required if laryngeal tuberculosis should manifest itself, as it occasionally, though rarely, does, in the form of a distinct tumour, which cannot be removed intralaryngeally.

In the third category, in which the whole, or nearly the whole, of the mucous membrane of the larynx is one mass of ulceration, and in which there is often in addition evidence of perichondritis and chondritis or even of caries, necrosis, and exfoliation of one or several of the laryngeal cartilages, curative local measures are, in my experience and belief, practically out of the question. Very heroic procedures, I know, are sometimes undertaken even in this class of cases, necrotic arytenoids are removed *in toto* with their swollen and ulcerated mucous coverings, and pure lactic acid or very strong solutions of that drug are forcibly rubbed in all over the larynx. I am not aware that such measures have ever acted beneficially, whilst they may intensify the violence of the local process, and they are certain, in spite of previous cocainisation and subsequent orthoform insufflation, to increase for a time the patient's sufferings. To remove a tuberculous larynx deliberately I consider hardly justifiable. Palliative local measures alone are, in my opinion, suitable in the great majority

of this class of cases, and nothing has so well served me to soothe pain and render swallowing possible as insufflation of orthoform. Its effects last much longer than those of cocaine, menthol, or morphine, and its dose has not to be rapidly increased like that of the drugs just named. Nor are general toxic symptoms ever observed. It has been accused of producing sloughing; I have never seen it cause such an undesirable effect.

Thirdly, in cases of laryngeal tuberculosis the patient's general health and pulmonary condition have always to be taken into consideration when deciding upon the question of local treatment. It must not be thought that even somewhat advanced lung disease or slight habitual feverishness necessarily contra-indicate local treatment of the larynx. I have often enough seen general beneficial results, even under such conditions, from arresting the laryngeal complication. But when practically the final stage of pulmonary phthisis has been reached, with marked hectic fever and cachexia, or when the tuberculous process is of the miliary type, I consider local treatment of the larynx other than palliative distinctly contra-indicated, and I would strongly warn against unduly exalting the laryngeal complication under such circumstances at the expense, as it were, of the pulmonary disease.

Fourthly, and finally, it is most important when local treatment has been decided upon in a case of laryngeal tuberculosis, that it should be efficiently carried out. This would seem to be almost a truism, but indeed it is not, and I think some plain speaking here is necessary.

Within my own knowledge often enough when energetic lactic acid and curetting treatment has been recommended, that advice has been only partially carried out, and in such a half-hearted way as to make it practically ineffective. Whilst the *rationale* of the treatment consists in the removal of the tuberculous ulcer and in the production of a healthy cicatrix, which purposes can only be obtained by thoroughly scraping the diseased area, or even removing parts of it with cutting forceps or double curette, and by subsequently energetically rubbing into the raw surface left behind a strong solution of lactic acid, carried to the part on a strong, stiff, properly-bent instrument, such as Krause's wool-carrier—all this, be it remembered, under the guidance of the laryngeal mirror—I find that the first part of the treatment, namely, the removal of the tuberculous tissue, is often omitted altogether, and that the rubbing in of the strong lactic acid solution is replaced by the application “somewhere” in the throat of a weak solution by means of a camel-hair brush, or by the substitution of a “weak spray of lactic acid.” The result is of course *nil*, and the patient, who had been encouraged to hope for relief, is greatly disappointed. I venture to say that this is hardly fair, either to the patient, the method, or to the original adviser. I certainly consider it much less—if at all—derogatory for a medical man to frankly tell his patient that the suggested treatment to be effective demanded an amount of special technical skill which he did not possess, and that he therefore would advise him to put himself in practised hands to have it properly carried out, than

that he should spoil fair chances by ineffective execution. The simple truth of the matter is that this treatment should as much remain in the hands of experts as, say, the intralaryngeal removal of intralaryngeal growths. However, I may add that seeing the frequency of laryngeal complications in pulmonary tuberculosis, and the encouraging results of the sanatorium treatment of the latter, every physician attached to a sanatorium should, I think, make himself enough of an expert to effectively carry out during the patient's stay at the sanatorium the local treatment of laryngeal complications if required.

I know full well that what I have said about the principles of local treatment in laryngeal tuberculosis does not nearly exhaust the subject. Thus, I have not so much as mentioned the necessity of combining in all cases a rational general with the local treatment. But this I hope I may take as self-understood, and I trust that my remarks, incomplete as they are from pressure of time, may help you to decide in doubtful cases whether any, and if so what, form of local treatment should be adopted. I have only to add that in pharyngeal tuberculosis, which fortunately is very rare, the energetic application of strong lactic acid solutions has been at least temporarily beneficial in the very few not hyperacute cases I have seen, whilst in the very acute form I consider that only palliatives are desirable. —In nasal tuberculosis, which also is rare, the tuberculous deposits and ulcers should be thoroughly removed and cleaned by scraping, followed by lactic acid applications. Unfortunately, however, there is a great

tendency towards recurrence in this form, no matter how thoroughly the local treatment may have been carried out.

Syphilis.

Of the next disease on our list, syphilis, I need only say that I have for many years ceased to include local treatment as a routine measure in the treatment of specific affections of the upper air passages. This, of course, does not mean that I oppose local treatment in this class of cases if actually required. On the contrary ; in cases, for example, of caries and necrosis of the bones in tertiary syphilis of the nose, of extensive adhesions in the pharynx as a result of tertiary ulceration of that part, of fibroid stenosis or advanced perichondritis of the larynx of syphilitic origin, local treatment, and this of the most energetic kind, may have to come into play. But what I mean is that in my experience no daily applications of sulphate of copper or nitrate of silver to the ulcerating surfaces are required in addition to proper constitutional treatment. I served my specialistic apprenticeship in a school in which such applications were considered most important, but, as I have already stated on a previous occasion, since I have gradually discontinued them and relied upon constitutional treatment only, I have not found that improvement has taken place more slowly than in former days.

Central Nervous Disease.

We next come to affections of the upper air passages due to diseases of the central nervous system, which may require local treatment. Two questions here particularly demand consideration: the electric treatment of functional aphonia, and the indications for tracheotomy in bilateral paralysis of the abductors of the vocal cords due to tabes.

With regard to the first of these two points, you know that countless methods have been recommended for the treatment of functional paralysis of the adductors: massage of the neck, compression of the alæ of the thyroid cartilage, hypnotism and suggestion, methodical exercises of articulation, cold douches, pulling forward of the tongue, deep narcosis, on awaking from which the patient is engaged in conversation, etc. Without doubting the efficiency of other measures, I personally adhere to the use of electricity as the quickest means of restoring the voice. But I urgently advise you to proceed energetically in these cases, and to employ at once intralaryngeal faradisation, as I have but too often found that previous timid or gentle external application of electricity greatly deadens the patient's response to the electric stimulus, which otherwise, in my experience, usually has an almost miraculous effect even in long-standing cases. I think that every experienced laryngologist will support this statement.

Concerning the second question, namely, when tracheotomy is indicated in bilateral paralysis of the

abductors of the vocal cords in tabes, I hardly venture to give an apodictic advice.

More than twenty years ago I proposed that in every case of bilateral, well-developed paralysis of the abductors in which it was impossible to bring about by suitable treatment a greater widening of the glottic space, prophylactic tracheotomy should be performed in order to secure the patient from the ever-present danger of suffocation. That advice, I think, has been very generally acted upon, and it certainly offers the best chances to the patient. But since then we have learned that in cases of tabes, sometimes, though by no means always, paralysis of the internal tensors and of the interarytenoid muscle supervenes years afterwards upon the original paralysis of the posterior cricoarytenoid muscles, and results in a wider opening of the glottis, and a diminution of the danger of sudden suffocation. A considerable dilemma has thus arisen. If one sees, as I have actually seen, quite a number of tabic patients who have lived with an extremely narrow glottis for a number of years without apparently suffering much inconvenience, and without ever having had a really serious attack of choking; and if one remembers in addition that the condition, as just stated, may actually improve slightly of its own accord, one fears to be accused of "lust of operation," if one, nevertheless, insists on prophylactic tracheotomy. If, on the other hand, we bear in mind that these patients live under a constant cloud of being killed, before medical aid can be called in, by a simple intercurrent laryngeal catarrh; that some of them have actually died from

sudden asphyxia ; that others have only been saved by a hairsbreadth by means of hurried tracheotomy ; and, finally, that after such hurried tracheotomies performed for chronic obstruction, unpleasant pulmonary complications are anything but rare, the possible consequences of postponing the operation must seriously weigh upon our mind. The best policy under these circumstances would seem to be fully to explain the situation to the patient's general medical adviser, or, failing him, to the patient himself or to his family, and not to bear the responsibility alone.

3. LOCAL MANIFESTATIONS IN NOSE AND THROAT, DEPENDENT UPON LOCAL DISEASE OF CORRELATED AREAS.

That not only systemic diseases, but also local affections in areas anatomically or otherwise connected with the upper air passages may engender trouble in these parts is a well-known fact. I need only remind you of laryngeal paralysis due to compression of the vagus or recurrent laryngeal nerves by aneurysm of the aorta, cancer of the œsophagus, enlarged mediastinal or cervical lymphatic glands, or of tracheal stenosis due to pressure from a fibroid or malignant goître as examples of such contingencies. You know equally well that in such cases, whilst symptomatic treatment may be required locally, it must be our aim to remove, if possible, the original source of the trouble. All this is so self-evident that I should not even have mentioned it, were it not that the sound principle just

referred to, namely, that if possible the original cause should be removed, instead of the secondary result merely being symptomatically treated, has of late unfortunately been exaggerated in this connection to such a degree that it seems time to seriously protest against this exaggeration.

I refer to the influence which is nowadays believed by some to be always exercised by the state of the nose upon inflammatory conditions of the pharynx and larynx. That such an influence exists within certain bounds, and provided that there is actual chronic stenosis of the nasal passages, is, of course, undeniable, and has been directly admitted by me in my first lecture. One of the most important functions of the nose is to moisten, to warm, and to purify the inspired air. If that function is abolished or greatly diminished in consequence of permanent obstruction, it goes without saying that inflammatory conditions in the pharynx, larynx, and lower air passages will be more likely to occur, and less likely to be remedied by topical treatment of the inflamed parts, than if the nose were fulfilling its normal functions. Under such circumstances it will, therefore, be just as much the practitioner's duty to remove the chronic obstruction of the nose, be it due to polypi, deviations of the septum, enlargement of the turbinated bodies, or whatever else, and not to be satisfied with mere symptomatic treatment of the pharyngeal or laryngeal inflammation, as it would be, not merely to relieve the dyspnœa caused by a hard goître by tracheotomy, but to remove the goître itself. But this legitimate and rational position has unfortu-

nately not satisfied the ambition of that section of modern rhinologists for whom the nose is the centre of the pathological universe. Gradually the equally deplorable and ridiculous doctrine has been developed that such a thing as a primary inflammatory process in the air passages below the nose did not exist at all, and that when inflammations occurred in these parts one had always to look for their starting-point in the nose. This sounds almost incredible, but nevertheless is perfectly true. Some time ago a case of laryngeal perichondritis was shown at a society of specialists. Opinions were divided as to whether tuberculosis, syphilis, or malignant disease was the cause, when one gentleman rose and asked the demonstrator in all seriousness whether he had observed that the patient had got a spur in his left nostril ?

The worst of it all is that these views are not merely held theoretically, but that they are actually carried into practice ! Let me give you a few very characteristic illustrations from my own experience. Some time ago I saw a patient suffering from laryngeal cancer, which appeared in the form of a general infiltration of the mucous membrane of one-half of the larynx. Before the patient came to me he had been treated by another specialist with nasal inhalations for the hoarseness which was the initial symptom of the disease !—Another patient, a well-known actor, had just produced a new play, the success of which almost entirely depended upon his own performance, and which promised to be very successful, when he was prostrated by influenza. The run of the piece had to be interrupted, and the

patient in despair returned to his work before the acute stage was over. He became hoarse the first night, and quite aphonic the third. He then consulted a staunch believer in the omnipotent influence of the nose, who declared that a somewhat biggish operation in that organ, about the nature of which the patient could not give particulars, was indispensable for the restoration of the vocal powers. As the patient had never in his life had the least trouble from his nose, he asked his usual medical adviser whether he should submit to the operation, and that gentleman suggested that he should consult me first. I found nothing whatever in the nose that in my opinion required operation, but there were marked congestion and swelling of the vocal cords, such as was natural enough after an attack of influenza and premature forced use of the voice. A few days' complete vocal rest and applications of astringents to the larynx effected a lasting cure.—In the third case the patient, a stockbroker, had got chronic laryngeal catarrh from habitual over-use of his voice in the Stock Exchange. Before he came to me he had been treated for fully six months by removals of crests from the nasal septum and by chemical and galvanic cauterisations of the mucous membrane covering the turbinated bones, although he had never had the least discomfort in his nose. And so strongly convinced was his medical attendant evidently that it must be the nose which caused the laryngeal trouble, that it never occurred to him to treat the really affected part—that is, the larynx. The same treatment as that adopted in the previous case effected a complete cure within a few weeks.

But the most drastic example I have ever seen of "nasal prejudice," if I may so call it, was afforded to me only a few months ago. An extremely neurotic gentleman had, when a student at Oxford twenty years ago, frequently suffered from severe abdominal pain, for which he several times consulted one of our most pains-taking physicians, who, however, never discovered any organic cause of this neuralgia. Later on the patient emigrated to one of the colonies, made a position for himself, and entered public life. Having on some occasion been compelled to make a series of public speeches, although he was already hoarse when he started, his vocal powers in the end failed him, and he felt a good deal of pain in his throat when speaking. He consulted a local specialist, who told him that he had, not only chronic laryngitis, but also swelling of the turbinals. Previous to this the patient had never been conscious that there was anything amiss with his nose. Nevertheless, he was treated for several months with a series of cutting operations in his nose, after one of which secondary hæmorrhages so serious and repeated occurred that the nose had to be plugged repeatedly, and that the worst was feared for a time. At the end of it all the patient became thoroughly neurasthenic, and his doctor advised him to return to Europe, and to see the physician who had treated him for his abdominal pains. That gentleman sent him on to me, as he could discover no organic mischief anywhere. The patient, a tall, well-built man, when entering my consulting-room, told me in a perfectly natural, sonorous voice, that he had come to consult me about his throat. The next sentence was

spoken in an absolutely toneless whisper. He begged me to let him whisper, as it "hurt" his throat when he spoke in his natural voice. Examination showed that the larynx, with the exception of very slight congestion of the vocal cords, was perfectly normal. Nothing abnormal could be detected in his nose, nor in the rest of his air passages. In short, it was a case of true "phonophobia." A consultation was held with his London physician and his colonial adviser, who happened to be in town, and it was decided to let him undergo a rest cure. I have just heard that his throat and voice are all right now, but that he still complains of occasional pains in his abdomen and hands, and that he thinks of trying hypnotism for these complaints.

Here, then, are four cases, gentlemen, which have the common characteristic that the cause of the patients' complaints was sought for in the nose, although they had never suffered the least inconvenience in that organ, and although there was—in the first three cases, at any rate—a fully sufficient explanation of their complaints to be found in the actual condition of the larynx and in the previous history. One of them escaped—fortunately for him—what would have been an absolutely uncalled-for operation in the nose; in the three other cases the nasal treatment was a dismal failure. These cases, therefore, show the actuality of a movement which I am convinced runs equally counter to the interest of the public and to the esteem in which I wish rhinology to be held by the profession, and they fully justify, I think, my warning that it is high time to drop the fanatic and narrow-minded notion that in all inflammatory

affections of the pharynx and larynx the cause must be sought for in the nose. By all means make it a practice to examine that organ carefully in all cases of inflammatory or obscure disease of the air passages, and when you detect a degree of nasal obstruction which gives legitimate reason for concluding that without its relief the affection lower down would either remain obdurate or speedily recur, remove it, or treat it otherwise appropriately; but when there are such obvious and sufficient explanations of the patients' complaints, as in the cases just narrated, do not blind yourself and run the risk of serious misunderstanding of your motives by assuming that some ridiculously small deviation from the normal, which you may happen to detect in the nose, must be the cause of all the trouble.

4. AFFECTIONS OF THE UPPER AIR PASSAGES SUPPOSED TO EXERCISE AN INFLUENCE UPON OTHER ORGANS AND PARTS OF THE BODY.

In a sense this division is a direct continuation of the preceding one, inasmuch as we shall in it again witness the regrettable spectacle of an originally sound principle being hunted to death through being ludicrously exaggerated. This applies to both forms in which an influence may be exercised by affections of the upper air passages upon other parts of the body, the direct and the reflex. Let us first consider the former.

A. Direct Influence.

It goes without saying that such an influence exists, and that often enough it is most marked. When an acute or chronic catarrh or inflammation spreads from the nose through the naso-pharynx and the Eustachian tubes to the middle ear, and effects corresponding changes in that organ; when owing to the mechanical obstruction caused by adenoid hypertrophy the type of the face alters, deafness is produced, and pigeon-breast is formed; when chronic septic poisoning is being produced by the constant absorption of purulent nasal discharges into the system; when in chronic stenosis of the larynx or trachea, pulmonary troubles, emphysema and chronic bronchial catarrh, cardiac dilatation, renal stasis and its sequels arise through impeded interchange of gases in the lungs—the relationship of cause and effect is at once obvious, and in all these cases, when the question of treatment is discussed, the grave consequences which may result for other organs or for the general health, if the affection of the upper air-passages be allowed to continue unhindered, will have to be taken into serious consideration.

But here, again, zeal has but too often, unfortunately, outrun discretion. That *enfant terrible* of modern medicine—the nose—is, in the opinion of some of its more stubborn devotees, the source of most, if not all, of our* woes, and even lesser degrees of so-called “nasal inadequacy” possess, to listen to them, an importance which I, for one, do not admit. Their

frequency I will not contest. In fact, I verily believe that, if the severe standard of nasal patency which some rhinologists apparently demand were compulsorily introduced to-morrow, a very large proportion of mankind would have to be subjected to a series of "patefying" operations (if I may coin that word). Now, if people who are inconvenienced by the fact that they cannot breathe as well through one of their nostrils as through the other choose to undergo an operation for an improvement of this condition, that is their own business, and concerns nobody else; but matters seem to me rather different if such operations are proposed and undertaken, as they nowadays frequently are, because dire consequences are apprehended and predicted for the general well-being, and more particularly for the auditory functions of the patient, on account of lesser degrees of nasal insufficiency, or because a patient who suffers from sclerotic middle-ear or labyrinthine disease at the same time has got a spur or a deviation of the septum, or some swelling of the nasal mucous membrane. I do not pretend to be an aurist, but I hope I possess an average quantity of common-sense, and I must freely confess that it is perfectly unintelligible to me how a slight degree of obstruction of the nose proper, particularly when it is one-sided, can be believed to exercise that disastrous influence upon the ventilation of the middle ears which I so often see ascribed to it. Pray do not misunderstand me here. I speak, of course, of stenosis of the nasal chambers proper only, not of actual occlusion or obstruction of the Eustachian tubes. The very great and important difference between these two

conditions is, it seems to me, hardly taken sufficiently into account at the present moment. That total obliteration or any serious diminution of the lumen of the Eustachian tubes—be it induced by a disease primarily situated in the naso-pharynx, or directly propagated from the nose to the tubes through the naso-pharynx—must entail a far-reaching influence upon the ventilation of the middle ears, and thus upon the whole auditory apparatus, goes without saying. But the matter is very different, indeed, if the stenosis is limited to the nose proper and if the naso-pharynx itself remains free. Under such circumstances—that is, when the naso-pharynx is ventilated through the mouth—the atmospheric pressure in it surely remains exactly the same as if it were ventilated through the nostrils, and I see not the least reason why any disturbance in the ventilation of the middle ears should result. If I should be asked here—Why, then, transitory slight deafness should so often accompany an ordinary “cold in the head,” I should answer: Because in such cases the swelling and congestion is not limited to the mucous membrane lining the interior of the nose, but actually extends through the naso-pharynx into the Eustachian tubes. When, however, the naso-pharynx itself remains free, the obstruction in the nose may be very considerable or even absolute, and yet no deafness nor any other symptoms on the part of the ears need follow.

This is no theory: it is a stern fact. If mere partial obstruction of the nose proper could exercise that great influence upon the auditory apparatus which is claimed for it, surely ear complications ought to be regularly

present in a class of cases in which nasal breathing is entirely or nearly entirely abolished—namely, in cases of multiple nasal polypi. Now, for many years, I have paid special attention to that question, which seems to me to be of great importance in the consideration of the point under discussion, and I am able to state, on the basis of a large material, that even in cases of complete obstruction of both nostrils by multiple polypi, ear complications of any kind have been extremely rare in my practice. And if further evidence were needed, it is afforded by the fact that even in cases of complete bilateral congenital occlusion of the choanæ by bony or membranous diaphragms, perfect hearing power and absence of any other aural symptoms have been observed by others as well as by myself.

You will understand, then, that I profess myself to be rather sceptical concerning the asserted great influence of nasal stenosis without concomitant chronic catarrh upon all possible ear troubles, and that I look upon an endeavour to improve labyrinthine disease by removing a crest from the nasal septum with feelings much akin to those which animate me when I see primary inflammations of the larynx treated by way of the nose. In connection with this, I was very glad to see that, in the discussion which took place at Ipswich last year on the question whether, since the introduction of modern rhinological methods, direct and considerable progress had been made in the treatment of ear affections associated with simple nasal stenosis, the general verdict was much less enthusiastic than would appear from some individual utterances and publications.

B. Reflex Influence.

Here we come to the subject of "nasal reflex neuroses," in my humble opinion one of the most unsatisfactory in modern medicine. I have only recently treated that subject in a special lecture, and have since then seen no reason to modify, or to add to, the views I expressed on that occasion. Permit me, therefore, freely to quote from my lecture what I consider its salient points, and to answer an objection that has been raised against my statements by Dr. Dundas Grant.

In 1884, the late Professor Hack of Freiburg stated that conditions of nervous hyper-excitability in the most various parts of the human body could and did take their origin from a sudden and transitory swelling of the cavernous tissue covering the anterior ends of the lower turbinated bodies. The reflex irritability of the nasal mucous membrane was, according to him, dependent upon the expansibility of certain "erectile organs" ("*Schwell-Organe*") situated within them. The latter being irritated at first, the cavernous spaces themselves were filled with blood. The congested condition of the nasal mucous membrane appeared to act as a stimulus for excitation of the nerve-end apparatus, and then reflexes, most frequently secretion of tears and of serous fluid from the nose; later on sneezing, occurred. From this hypothetical reasoning, Hack further concluded that the nasal erectile organs formed a sort of link between various forms of nerve irritation. On the one hand, he

considered it quite possible that a reflex irritation could produce congestion of the cavernous tissue. On the other hand, he thought that nervous symptoms manifesting themselves in different parts of the body could originate from the congested state of the cavernous tissue of the nose. Starting from this hypothesis, he reasoned that, if one eliminated by operation the supposed connecting link, namely, the erectile organs situated in the nasal mucous membrane, one might succeed in curing many of the obscure neuroses which, in his opinion, had their origin in the nose, and which, so far, had obstinately resisted all possible methods of treatment.

Hack's original list of these was large enough in all conscience, including as it did spasm of the glottis, nightmare, asthma, attacks of spasmodic cough, megrim, supra-orbital and other neuralgias, amblyopia and amaurosis, erythema or pseudo-erysipelas of the nose, giddiness, epileptiform attacks, secretory neuroses, ciliary scotoma, headache, hay fever, etc.; but this list sinks into insignificance when compared with the additions which his followers soon made: Graves's disease, diabetes, irregularity of the heart's action, tachycardia, stenocardia, angina pectoris, cardialgia, diseases of the stomach, dysmenorrhœa, chorea, enuresis nocturna, melancholia, neurasthenia, catarrhal affections of the air passages, epiphora, hyperæmia and œdema of the conjunctiva and the eyelids, blepharospasm, strabismus, pupillary changes, errors of accommodation, asthenopia, narrowing of the field of vision, anomalies of the ears and of the genital sphere, spasm of the facial and other motor nerves, muscular pains, stiffness

of the neck, exudations in the joints, changes of the skin, etc.—all these were added, and as Professor Jurasz has truly remarked : “ One was almost induced to believe that a great part of general pathology was dominated by morbid reflexes from the nose.”

Nor did the current of opinion remain within the limits of theory. Whenever anybody suffering from an obscure neurosis had the misfortune to fall into the hands of a rhinological enthusiast, particularly within the first few years after Hack's publication, the cause of his ailment was detected in his nose, and treated accordingly. Hack's followers were not satisfied with the original discoverer's limitation of the zone of reflex irritability to the anterior ends of the lower turbinate bones. In rapid succession it was found out that such zones also existed in the posterior ends of the lower and in the middle turbinate bones (this addition was made by Hack himself), and in the septum (Baratoux and Heryng); and the matter reached its climax when it was stated that excitation of certain parts of the nasal mucous membrane was responsible for certain forms of reflex neurosis. Forstensson (Pan-American Congress, 1892), according to Jurasz, stated that he had discovered the specific point of excitability in no fewer than four hundred cases of asthma in the upper part of the septum. Fliess, according to the same authority, found a corresponding point for nervous cardialgia of nasal origin in the anterior third of the middle turbinate bone, for the abdominal pains of dysmenorrhœa in the lower turbinate bodies, and for the pains in the small

of the back observed in the same affection in the tuberculum septi! Cough for some time seemed to have no other origin than in the nose. I vividly remember how, in 1885, a patient was sent to me with a letter by a German *confrère*, who requested me to finish the intranasal treatment of the patient's cough, which he had started, he thought, with marked effect—a view from which I regret to say the patient's own opinion differed. When I found that the latter, besides various constitutional signs of pulmonary tubercle, showed evidences of consolidation of both apices, and a temperature of over 100° at 6 P.M., I did not feel quite justified in finishing the intranasal treatment!

Above all other affections, however, asthma was declared to be most frequently of nasal origin, and to demand energetic treatment applied to the nose. Who can count the number of luckless asthmatics whose noses have been burned between 1882 and the present day? Personally, I was not at all over-sceptical, or prejudicially inclined against the new doctrine. On the contrary, having, previous to Hack's publication, observed a few cases myself which seemed to lend colour to it, I was quite prepared to look upon Hack's statements as opening up a new era for rhinology. But when, in quick succession, in a number of cases of asthma, megrim, and neuralgia of the fifth nerve, which I had most carefully selected according to the principles laid down by Hack himself, the effect of the treatment remained perfectly negative, I became more sceptical, and I regret to have to say that this

scepticism, to which I gave expression in 1884 in the German edition of Mackenzie's text-book, has not been changed by my subsequent experience.

Not that I wish to be understood as if I altogether denied the possibility of reflex neuroses taking their origin in conditions of abnormal excitability of the nasal membrane. Such a position of absolute negation, in my opinion, would be as unjustifiable as the excessive enthusiasm even now displayed by some adherents of Hack's doctrine. It cannot be denied, and shall not be denied, that in some cases in which an acquired or hereditary predisposition to nervous ailments goes hand in hand with a local hyper-irritability of the nasal mucous membrane and of the nerve-end apparatus expanded in it, occasionally reflex symptoms, and of a severe type too, may be produced in other spheres. I have myself successfully treated a few cases of asthma of nasal origin; I have in an isolated case been able to produce with mathematical regularity an attack of most violent spasmodic cough as soon as I touched with the probe a small spot in the middle third of the septum nasi on the left side, and I have observed a case in which night terrors, spasmodic sneezing, and asthma disappeared in proportion to the reduction of morbid conditions in the patient's nose. After such and similar experiences, it would be folly to condemn the whole doctrine of nasal reflex neuroses as fallacious and misleading; but I am deeply convinced (1) that the frequency and importance of the influence of the nasal mucous membrane upon nervous phenomena at distant parts has been grossly

exaggerated by the adherents of the doctrine; (2) that we have no real understanding as yet of the mechanism of these reflex processes; (3) that it is most difficult to determine whether a neurosis really is of nasal origin or not; and (4) that it is equally difficult, whether, in cases in which a nasal origin seems to be likely, treatment directed to the nose will benefit the patient.

All we can say is that in a certain number of cases physiological reflexes are produced from the nose, just as a reflex cough is sometimes produced from the external auditory meatus, and that what is true of the physiological sphere equally applies to the pathological. The affection which I think may practically serve as a type of nasal reflex neuroses is hay fever. Here, indeed, we see that in a number of cases in which the mucous membrane is in a pathological condition, judicious treatment of that part just previous to the periodical complex of symptoms (sneezing, rhinorrhœa, conjunctivitis, epiphora, asthma) which constitute a complete attack of hay fever, in a considerable proportion of cases either stops the attack completely, or at any rate curtails its duration and diminishes its violence. This is a fact which I have often enough observed myself in the course of the last twenty years. Similar beneficial effects, although without anything like a similar frequency, may be observed in cases of genuine bronchial asthma, complicated by the existence of nasal polypi. Thorough removal of the latter in a number of these gives the patient lasting or temporary freedom from his asthma without any other treatment being employed. The

relationship of cause and effect in some of these cases is very striking, inasmuch as on the return of the polypi the asthma occurs again, to disappear anew when the nasal disease has again been successfully treated.

Far be it also from me to doubt the possibility that other nervous affections may be beneficially influenced by the treatment of morbid conditions of the nose. Considering the intimate relationship of the fifth nerve to so many of the other cranial nerves, particularly the pneumogastric, and also to the sympathetic system, it is quite conceivable that a centripetal irritation having been caused by disease in the periphery of the fifth, and having found its way to the cerebral centres, and thence to distant nerve territories, may be arrested by elimination of the original irritation.

Hack's doctrine could never have attained so much popularity as it did if there had not been something rational in these hypotheses. The great mistake, however, which his enthusiasm led him to make originally, and which I believe his adherents are still making, was that he generalised too quickly from a number of neurotic patients in whom this local treatment may have had a temporary effect, either in the manner of a suggestion or of a pure counter-irritation. He took this effect to be an assured and a lasting one, and thereby was induced to regard as well-ascertained facts results which later and calmer observation has shown to be of an exceedingly doubtful and frequently unstable character.

And the worst of the whole matter, as already stated, is that, so far as I can speak myself, we are not in a

position to say beforehand in the great majority of cases whether a neurosis is due to reflex influences from the nose or not. This fact of course renders the position, not only of the diagnostician, but of the therapist, extremely difficult ; inasmuch as there are not, so far as I know, in spite of all the various directions that have been given, any really reliable indications from which one is enabled to give a trustworthy prognosis with regard to the effect of nasal treatment in these cases.

Asthma.

Take, for instance, 3 cases of genuine bronchial asthma, which are sent to a rhinologist because, after careful exclusion of all other causes (affections of the heart, kidney, lung, stomach, etc.), nothing seems left but to ascribe the troublesome disease to nasal obstruction, from which all 3 cases have suffered for many years. Let the pathological conditions observed be in all 3 cases exactly the same, namely, very considerable swelling of the anterior parts of the lower turbinated bones, interfering even under ordinary conditions with nasal respiration, and obviously aggravating the respiratory difficulties during the asthmatic attack. The similarity of the local conditions in the nose in all 3 cases may be such that if the patients' faces be covered, it would be impossible to distinguish them from one another. Yet, if they all be treated exactly alike, namely, by galvanocaustic reduction of the swollen parts, absolutely different results may be obtained : in the one case a complete cure of the asthma, in the second case tem-

porary disappearance, or, at any rate, improvement of all the troublesome symptoms; in the third no effect whatsoever. Yet, I repeat, the local conditions in all three were perfectly indistinguishable from one another. And the worst of it is that the proportion of the really successful cases in my experience is very small compared with those which are only temporarily benefited, and even much more so in proportion to the absolutely unsuccessful ones.

The correctness of this statement will probably not be admitted by ardent rhinologists. They will tell you that they obtain a much larger percentage of cures, and of long-lasting improvements. Whilst I am preparing this lecture, I read in an American journal a paper, whose author begins as follows :—"The frequency of asthma as a result of a diseased nasal condition has so often been brought to my notice that I feel hopeful of effecting a cure in every (!) case of this distressing malady that consults me. Unfortunately, I am occasionally disappointed, but only in a small minority of my cases." Well, gentlemen, I can only say that he must be a very lucky man who has penned these lines. Otherwise I am not able to understand his own and similar statements. If in an operation in which great technical skill and large experience are of the utmost importance, the results of individual operators vary greatly—that is intelligible enough. But if, in a question like the one under consideration, in which the technique is of the simplest, one man speaks like our American friend, and the other as I am unfortunately compelled to do, the only possible explanation seems that the former has

had unheard-of luck in the nature and selection of his cases, whilst the latter has been phenomenally unlucky.

This brings me to the curious interpretation which Dr. Dundas Grant has recently given in his address on "Traps and Pitfalls in Medicine" of my inability to join the chorus of the apostles of the nasal cure of asthma. He says :—"Asthma is another disease in the treatment of which general medicine owes much to the specialist, and every practitioner in diseases of the nose must have before his mind cases in which the treatment of the nasal cavity has resulted in long and even permanent relief from the suffering depending upon this disease. Sir Felix Semon has indeed said that only a small percentage of the large number of cases of asthma which were at one time brought to him by physicians were traceable to nasal disease or relieved by nasal treatment. His experience, however, has been exceptional, for a reason not far to seek. At the time when attention was first drawn to the dependence of asthma in a certain number of cases, at least, upon nasal disease, Sir Felix Semon already had in so high a degree the confidence of physicians at large that cases of asthma were brought to him in large numbers, on the supposition that he was to find nasal disease in them all. He was naturally disappointed at the inevitable result in a considerable proportion of the cases. At the present time physicians make a rational search for nasal symptoms, and when such are present or suspected, then only are the patients brought before the notice of the rhinologist, and under such circumstances the

percentage of beneficial results is by no means a contemptible one."

That is, indeed, a curious explanation. In the first place, what Dr. Grant states in it as to the manner in which my views have been formed are not facts, and he certainly cannot have derived his statements from my own writings, for I have never said anything that could possibly justify his purely theoretical description. Secondly, I feel sure that he wished to express his dissent from my views in the most courteous fashion, but I am afraid he has overlooked that the form chosen pays but a poor compliment both to my intellect and to my honesty, for he makes it appear as if I had, when the whole question was new, operated "by order" upon numerous cases without using my own judgment, and as if I had later on obstinately stuck to opinions arrived at through indiscriminately operating in the first instance. I can assure Dr. Grant that he is entirely mistaken in both respects. If he had read what I have written on the question since 1884, he would have found that from the first I have used my own discretion in selecting my cases for nasal treatment, and I need hardly say that if subsequent experience had corrected my first impressions, I should have considered it my plain duty to publicly correct erroneous views to which I had given currency in good faith.

However, these are personal matters which are of little interest to the public. What is of much greater importance is Dr. Grant's assertion that my experience was "exceptional." This really is an astounding statement. On May 5th, 1899, a discussion took place in

the Laryngological Society of London on "Asthma in its Relation to Diseases of the Upper Air Passages." Of this discussion my friend, Mr. Ernest Waggett, has made a careful abstract in tabular form, which he has kindly permitted me to use. Seventeen speakers took part in this discussion and reported their personal experiences, which are summarised in his table (printed below, see p. 102).

As a net result of this discussion, then, which was carried on, I repeat, by seventeen British physicians and specialists of long and extensive experience, we find that actual cures or considerable improvement were reported in nine—say nine—cases, in three of which adenoids, and in four of which polypi, were present, a truly magnificent proportion if one remembers how many hundreds of cases of asthma have been treated in this country alone by intranasal interference since 1884. And even so far as expressions of mere "opinions" are concerned, it will be seen from these tables that out of seventeen speakers only seven expressed themselves in anything like a hopeful strain, whilst the other ten held either very reserved or directly unfavourable opinions.

After this it is unintelligible to me how Dr. Dundas Grant can speak of my experience as "exceptional." I hold, not exceptional, but moderate views, which are shared, I am glad to say, by many of my fellow-specialists, and to these views I adhere. I always painfully feel when I see cases of this sort that by dissuading the patient from undergoing the treatment, if there be an actual morbid condition of the nose to which the

asthma could be rationally ascribed, one might possibly deprive the patient of his only chance of getting rid of his troublesome disease. To counsel him, on the other hand, to undergo a treatment which, though not painful, certainly is anything but pleasant, and may be very tedious, whilst one is convinced that in a very small proportion of such cases only real and lasting benefit is obtained, will be always very unsympathetic to a man whose turn of mind does not naturally enrol him amongst therapeutic enthusiasts.

Under these circumstances I always think it best in cases of that sort to speak, when one has to do with educated patients, as frankly as possible, and explain as far as one can the present state of the whole matter, without either urging or dissuading from intranasal treatment. This attitude, I think, does justice to both the patient and the practitioner.

It is devoutly to be hoped that more reliable indications may soon be laid down for our procedure in such cases. At the present time, whilst in some cases very pleasing and, in a few patients, altogether unexpected results are obtained, I regret to say that in my experience our knowledge with regard to diagnosis, and our results with regard to the treatment of nasal reflex neuroses are still extremely unsatisfactory.

Personal Experiences as to Asthma and Nasal Operations.

	Reports of Actual Cases.	Opinions Expressed.
Percy Kidd	2 polypi ; "manifest relief"	"Frequency of association much exaggerated." "Improvement in most cases temporary and incomplete."
McBride	1 cure, adenoids	"Reasonable to expect benefit from removal of polypi." "Mentioned several cases" in which benefit occurred.
Thorowgood	1 case, adenoids, almost free	"Quite right not to promise the patient cure from asthma."
Waggett	1 case, spur and bridges	Since date of meeting asthma returned, though nose practically normal.
McIntyre	—	"Could recall a few cases of cure," but these were a very small minority.
Tilley	—	None except questionable case with adenoids.
Scanes	—	"A few patients ready to maintain" they were cured. Majority got great relief.
Spicer	—	Very large proportion of a more or less prolonged amelioration or cessation.
Watson	1 case of practical cure (general treatment given also)	
Williams	1 case, polypi	—
Theodore Williams	—	Majority "great relief" until necessity arose for further intranasal operation.
Permewan	—	Fair proportion completely cured.
D. Grant	1 cure, polypi	"Thought that unless some definite evidence could be obtained that the source of irritation was in the nose; any operation, except for relief of obstruction, was hardly justified."
C. Beale	1 case relieved for a time by repeated operation	In over 50 per cent., where nasal disease present, relief might be expected.
Hill	—	Lasting success in exceedingly small percentage. In his experience most frequently no results obtained at all.
Semon	—	Had met cases which had been "considerably damaged" by intranasal treatment.
StClair	—	
Thomson	—	
Lack	1 case, adenoids	
De H. Hall	1 case, polypi	Very fair proportion of considerable and permanent relief.

5. LOCAL SYMPTOMS AND SENSATIONS OF OBSCURE ORIGIN.

At the head of this division I would place the principle : not to try and at any price to find the explanation of every symptom and every sensation experienced in the upper air passages in trivial or even imaginary deviations from the normal existing in these parts.

But here again I wish to guard against misunderstandings. Undoubtedly, when a patient consults us, complaining about his nose and throat, our first duty will be carefully to examine these parts. If we find in them a rational explanation of the symptoms complained of, so much the better. The case, then, will belong to the first category I discussed—to the affections of purely local character—and in that class, as I have tried to show, much may be expected from appropriate local treatment.

But the case is very different indeed if the actual changes met with are of so trivial a character as not to account for the symptoms present, or if they are of such a nature that to ordinary common-sense a relationship of cause and effect is practically excluded. Take, for instance, a case of hoarseness due to paralysis of the left vocal cord. It may as yet be impossible to make out the cause of the paralysis when the patient consults the doctor, but the latter would, in my humble opinion at least, act extremely unwisely if he were to accuse an accidentally concomitant elongated uvula as the cause of the hoarseness, and to remove that structure. Yet I have known cases in which this has actually been done,

and in which the real cause of the hoarseness ultimately turned out to be aneurysm of the aorta !—Or, to take another example : A patient comes complaining of some difficulty in swallowing. The doctor diagnoses, as was the fashion a few years ago, “varicose veins” at the base of the tongue, or at the posterior wall of the pharynx, and destroys them by the galvano-cautery. The patient is not relieved, and consults another doctor, who finds that the real cause of the dysphagia is commencing bulbar paralysis ! This, again, is not a fantastic example ; I have seen an instance of that kind myself. —Or, as in the case mentioned in the last division : A patient suffers from violent cough ; the cause is declared to be a spur of the septum, which touches the opposite turbinal ; operative treatment in the nose is resorted to without avail ; the patient sees another medical man, who finds that pulmonary tuberculosis is the real cause of the cough.

Few things, gentlemen, will damage the reputation of a medical man so seriously as mistakes of this kind ; few things will lend so much colour, as they do, to the accusation of narrow-mindedness which is so apt to be brought against specialists.

I have deliberately selected elongation of the uvula, varicose veins at the base of the tongue and at the back of the pharynx, and spurs of the septum as representative “scapegoats” for the explanation of all possible symptoms in nose and throat. In children, of course, adenoids may be added, and in adults granular pharyngitis, enlargement of the lingual tonsil, and hypertrophic rhinitis run them very close. But the

three first named were until very recently, in my experience at any rate, but too commonly held responsible for all the ills to which nose and throat are heir. Of these the oldest offender is undoubtedly "elongation of the uvula." Though matters, I think, are better now than they were twenty years ago with regard to this topic, it is still apparently believed in some quarters that cutting the uvula is a sort of "panacea" for all possible forms of throat disease, whilst in others it is looked upon as a "last resort" after the failure of other measures. Now, the operation itself is, of course, a very small matter, but the after-pain is, as I can assure you from personal experience, sometimes very great indeed, and when a patient has suffered acutely for several days without obtaining any benefit with respect to his original symptoms, it is not exactly likely that his love for the operator will be increased thereby. In my opinion the operation is extremely rarely required, and should only be undertaken if it can be ascertained beyond doubt that elongation of the uvula is at the root of the symptoms complained of.—The second "scapegoat," namely, "varicose veins" at the base of the tongue and at the back of the pharynx, or "piles" in the throat, as they were elegantly called, at one time raged with the fury of a regular epidemic, and were held responsible, not only for all conceivable throat symptoms, but can you believe it, gentlemen, for such affections as "spasmodic torticollis" and "paresis of an upper limb"! When, however, Dr. Herbert Tilley courageously pricked that bubble in 1896, it utterly collapsed, and wonderfully little

is nowadays heard, thank goodness, of "lingual varix." *Requiescat in tenebris!*—The third poor sinner, however, the spur on the septum, so far as my observations go, still flourishes, and though it may not even touch the opposite turbinal, is held responsible in some quarters for all possible nose, throat, and ear symptoms. It is devoutly to be hoped that it may soon share the fate of the "varicose veins"!

But, gentlemen, seriously speaking, this whole movement, this "morbid readiness to discover disease," this desperate trying to find in every case and at any price a local explanation which, I am sorry to say, has been again in the ascendant during the last few years, after having been victoriously combated in the early Eighties, is, I firmly believe, unsound, retrogressive, and greatly to be deprecated. I certainly do not wish to make myself the advocate of such expedients, as to refer every local sensation in the upper air passages to the question of "general health," or to rest satisfied with giving it a high-sounding name such as "paræsthesia" or "neuralgia." Such expedients are, I know well enough, but too often the "refuge of the destitute"! Personally, I am much more pleased if I find well-marked granular pharyngitis, which can be cured by a few galvano-caustic applications, in explanation of dryness and soreness of the throat, than an apparently normal mucous membrane when such sensations are complained of. But there can be no doubt, on the other hand, that many local symptoms and sensations actually do depend upon the general health, upon diseases in remote parts, upon purely functional nervous diseases, and that to

disregard these possibilities ; not to look further than to the tip of the nose or to the lower end of the trachea ; and to treat every tiny abnormality by chance existing in these parts as the real cause of the patient's symptoms, is as little calculated to do good to the patient as to reflect credit upon the medical attendant !

6. THE NECESSITY OF A PROPER PROPORTION BEING OBSERVED BETWEEN THE GRAVITY OF THE DISEASE AND THAT OF THE INTERFERENCE.

You all remember, no doubt, that delightful song in the *Mikado*, gentlemen, in which that enlightened potentate thus states the summit of his ambition :

My object all sublime
I shall achieve in time,
To make the punishment fit the crime,
The punishment fit the crime.

Would, gentlemen, that that sound principle, "To make the punishment fit the crime," were elevated to front rank in the considerations which ought to guide us when adopting local treatment in affections of the upper air passages ! But, alas, this is by no means the universal rule ! In previous divisions of these lectures I have had repeatedly to complain—as in the paragraphs dealing with adenoids, with laryngeal tuberculosis, with functional aphonia—that local treatment was by no means always efficiently carried out. In this—concluding—part it will, on the contrary, be my duty to warn against adopting measures the severity of which is quite out of proportion to the exigencies of the case. I shall

give you three instances, which will show you that such a warning is much needed. I will illustrate how excessive local treatment may err in various degrees from mere superfluity, through unnecessarily severe and dangerous procedures, and finally, through resorting to what I consider to be positively unpardonable measures.

Before, however, embarking upon this not very pleasant task, I feel I ought to say a few words concerning the new radical operation for nasal polypi introduced by Dr. Lambert Lack, lest my silence be misunderstood. Dr. Lack, being convinced from his investigations that the primary element in the formation of nasal polypi is a rarefying osteitis of the ethmoid bone, proposes, in all cases in which there is extensive bone disease with numerous polypi, in which frequent recurrences take place after operations, and in which there is suppuration from the ethmoidal cells or from the accessory sinuses, to remove radically the whole of the diseased bone under a general anæsthetic. Seeing the extreme obstinacy and tediousness of such cases, I fully agree that if it should turn out that the proceeding recommended is both safe and efficient, it would represent an enormous progress over our present methods. But it remains as yet to be seen whether these two demands, safety and efficiency, will be fulfilled by the radical method, and until we are in possession of larger experience concerning them I refrain from expressing an opinion. I already have knowledge and details of a case in which death from acute meningitis occurred some three to four days after the operation in a patient who had, except for nasal

polypi, been in good health. As Dr. Lack himself warns us: The lamina cribrosa is not a part to take liberties with.

Coming now to affections in which I believe that but too often the severity of the interference is out of proportion to that of the disease, I select as an illustration of that class in which energetic and prolonged local treatment is, in my opinion, absolutely superfluous, the affection described as leptothrix mycosis, or as keratosis of the tonsils, base of the tongue, and pharynx. Aside from the question whether the leptothrix or the cornification of the epithelium prevails, in both instances white, rather hard, firmly-adherent projections are seen to protrude from the crypts of the palatal and lingual tonsils, and, more rarely, from follicles on the posterior wall of the pharynx and the palatal arches. As a rule they produce no symptoms whatever, and, in my experience, are usually detected by the patients themselves on a chance inspection of their throats. The patients are then apt to be much frightened by the strange appearance, and consult a doctor for what they call an "ulcerated" throat. Occasionally they complain of various unpleasant sensations, which, however, I am loth to attribute to the tonsillar affection, as I have almost always found this mycosis or keratosis in people whose general health has been low for some reason or other, and who often enough complain of such sensations without any tonsillar complication being present at all. The harmlessness of the affection is only rivalled by its obstinacy to local treatment. Whatever method be used—and

the name of the remedies and operative measures recommended in these cases really is legion—no sooner have the protuberances been removed than they reappear. Some time ago it was stated in a discussion that a case of this sort had been treated for three months with the galvano-cautery without success. Even when with great patience and endurance complete removal appears to have been effected, recurrence is extremely apt to take place.

Now what I wish to emphasise is that no local treatment whatever is required in these cases. Speaking from large experience, I can confidently state that if the patients be assured that there is nothing serious the matter, and if they be ordered change of air, tonics, rest, open-air exercise, etc., they will get well without local treatment of any kind. Indeed, I believe that many of these cases are never seen by a doctor because the affection arises and disappears without causing any symptoms.

Whilst in the category just discussed local treatment in my opinion is simply superfluous, it may do a good deal of harm, both immediate and remote, if indiscriminately and excessively employed in the class of cases to which I now invite your attention, namely, in enlargement of the posterior ends of the lower turbinals, be this enlargement of a merely congestive or a truly hypertrophic character ("moriform hypertrophy"). Undoubtedly in a certain number of such cases the obstruction to breathing caused by the swelling of those bodies is so great, that it must be removed. Until recently this was technically no easy matter, as it is often extremely

difficult to pass a snare over the posterior ends of the lower turbinals, however much enlarged they may be, and as other procedures, such as the application of the galvano-cautery or submucous incisions, are both tedious and uncertain in their effects. With the invention of Carmalt Jones's "spokeshave" all this was suddenly changed. A single forward draw of the ring knife, previously applied over the posterior ends of the lower turbinal, and out came the whole body! Nothing could be more simple, and nothing apparently for a time delighted the heart of the thoroughgoing rhinologist more, than to thus punish these rebellious structures. It was a common saying—malicious, I trust—not many years ago, that in a certain institution lower turbinals had to be swept up with a broom on operation days. But the proceeding, though simple, is not quite so harmless as was at first stated by enthusiastic apostles of the method. In not a few cases severe secondary hæmorrhage follows the operation. A leading London practitioner told me a little while ago that within a comparatively short time he had been called to no fewer than four of his patients, who, unknown to him, had undergone this operation, and had begun to bleed some hours or even days afterwards. In one case the hæmorrhage was so severe that he had to sit up the whole night with the patient. I have already narrated a similar case in a previous paragraph. Another and very serious, because lasting, possible sequel to ablation of the whole turbinal is, that by removal of so large a surface of mucous membrane which has to accomplish, as already mentioned, the important functions of warming,

moistening, and purifying the inspired air, a condition is produced very similar to atrophic rhinitis, with the result that exceedingly troublesome dry pharyngitis, with a tendency to formation of crusts and liability to laryngeal catarrh, follow. This is not, I beg emphatically to say, a theoretical apprehension. I, as well as others, have actually seen examples of so serious and irremediable a result after these operations. Fortunately, the initial enthusiasm has been quickly enough followed by a return to greater sobriety. I was delighted to see that at the recent meeting of the British Medical Association a firm stand was taken by many of the speakers in the discussion on the treatment of nasal obstruction against complete turbinectomy, which, as Dr. Brown-Kelly truly remarked, "had not redounded to the credit of British rhinology," and I think that, with very few exceptions, there is now a general agreement that even in cases in which removal of the posterior ends of the turbinals is indicated, the operation ought to be limited to these posterior ends, and not include, except in the rarest of instances, the entire body. In this connection I wish particularly to warn you against the notion which found expression on that occasion, that it did not much matter whether one removed a "useless" turbinate in its entirety or not. What is a "useless" turbinate?—We should do well to remember, I think, our similar experiences in the case of goître. The occurrence of myxœdema in cases in which goïtrous thyroid glands had been removed as "useless," taught us that they could, after all, not have been quite so useless as had been supposed, and the

occurrence of pharyngitis sicca in cases in which the entire lower turbinals have been removed under a similar belief should, I venture to believe, teach us a similar lesson.

But the worst exaggeration that has ever to my knowledge been perpetrated in connection with affections of the upper air passages was committed last year when Dr. John Mackenzie, of Baltimore, read before the American Laryngological Association a paper bearing the significant title, "A Plea for Early Naked-Eye Diagnosis, and Removal of the Entire Organ with the Neighbouring Area of possible Lymphatic Infection in Cancer of the Larynx." One hardly trusted one's eyes when reading that title, but on perusing the paper itself one sees that the author has, at any rate, the courage of his convictions. In all earnestness, he considers the naked-eye diagnosis a "comparatively speaking neglected method," emphatically rejects the removal of a piece for microscopic examination, and demands—however early the diagnosis may have been made, however limited the disease may be—not only "early total extirpation of the entire organ," but even of its "tributary lymphatics and glands, whether the latter are apparently diseased or not," as "the only possible safeguard against local recurrence or metastasis."

After these astounding performances one would like to give Dr. Mackenzie the benefit of the doubt and assume that, Rip-van-Winkle-like, he must have slept throughout the whole modern development of our knowledge of laryngeal cancer, particularly as he declares that "thyrotomy with curettement or removal of

all apparent (visible) disease is not up-to-date surgery, is in direct defiance of the rules that should govern us in the treatment of cancer, and is a reversion to and a resurrection of a method of procedure that was discredited and abandoned over half a century ago," were it not that such a plea is unfortunately inadmissible. Dr. Mackenzie was not only over here in 1895, when a long and instructive discussion on the treatment of laryngeal cancer took place in the Laryngological Section of the London meeting of the British Medical Association, but he himself took a leading part in it. He not only learned the views of his British colleagues on the question he now treats so passionately, but he also heard of the results they had obtained by the method which he now endeavours to disqualify as "not up-to-date surgery." These results he deliberately ignores. That is unpardonable. Mr. Ernest Waggett, in "the interests of American surgeons, and still more of American patients," has taken upon himself the very meritorious task of correcting in the same journal in which Dr. Mackenzie's paper was published his misleading statements, and of showing by facts and numbers the value of the method against which that author inveighs. Personally, however, I find it very difficult to take Dr. Mackenzie seriously, and I must confess that when I read his advice to condemn to a very serious and mutilating operation patients whom we have learned lastingly to cure by infinitely milder methods, I was irresistibly reminded of a certain Dr. Eisenbart, who is supposed to have flourished at the time of Frederick the Great, and who, in a well-known German

students' ditty, gives a frightful account of his heroic exploits, of which the following—in very free translation, I am afraid—may give you an idea :

At Potsdam I trepanned, just hear,
Great Fred'rick's cook, to him so dear.
I poleaxed his devoted head :
No wonder that the cook is dead.

I certainly prefer the Mikado's principle, and I hope that Dr. Eisenbart is not likely to find many emulators amongst contemporary surgeons !

With the expression of this hope, gentlemen, I conclude my lectures. Nobody can be more conscious than I am that I have brought forward nothing new, and that I have repeated in almost identical words much that I have said on previous occasions. But I honestly believe that such repetitions sometimes are required and may do good. Cato may have been, and probably was, a terrible bore with his eternal *Cæterum censeo*, but after all he thereby advanced his cause and ultimately obtained his purpose.

If I could venture to hope that by my warnings against excessive zeal and over-operating on the one hand, by my insisting on effectively operating on the other, I had advanced the good cause I have at heart, I should be perfectly willing to enrol myself on Cato's side.

APPENDIX

THE PRINCIPLES OF LOCAL TREATMENT IN DISEASES OF THE UPPER AIR PASSAGES

(a). *Letter to the Editor of the "British Medical Journal," published
November 23rd, 1901.*

SIR,—When a man embarks upon what you have very justly called the "most unpleasant task" of denouncing excesses, he must be prepared for all sorts of opposition and abuse. Considering the wide application of the principles I wish to see established, the large amount of ground covered by my criticism, the seriousness of some of my charges, I should not have been surprised if the reality of the evils attacked by me had been roundly denied, if I had been accused of gross exaggeration, and if the disinterestedness of my motives had been called into doubt. The pleasing absence of opposition of that kind emboldens me to hope that the purpose of my lectures has been correctly appreciated. If after two articles which deal with a number of far-reaching questions of principle, no more formidable opposition is forthcoming than a weak fault-finding with some questions of detail, it does not seem too rash, I hope, to conclude that the contentions in the main must have been sound.

An attempt, it is true, is being made by the first and third of your correspondents to argue in exactly the opposite direction. They endeavour to establish that I have committed some inaccuracies in details, and on the strength of these supposed inaccuracies hold me up to the scorn of your readers. We shall presently see whether I have been inaccurate.

I begin with Mr. Arbuthnot Lane's letter. Before entering upon its details I must say that it is most disappointing. Mr. Lane had gone out of his way to denounce a universally accepted operation as "unnecessary, imperfect, and unscientific." His utterances on the question have found their way—I hasten to interpose that I am quite sure without any fault of his—not only into a lay journal, but even into the prospectus of an establishment commercially

exploiting his principle. The soundness of this principle has now formally been challenged by me. Surely after that a scientific vindication of his views might have been expected—and, indeed, ought to have been forthcoming—from Mr. Lane's pen. But what do we find? All Mr. Lane has to say on that all-important point is this :

I do not desire at present to enter into a further discussion upon a subject which must be decided by experience and by that alone.

No doubt that is simple enough, but I am sure others will feel as I do, that it is very unsatisfactory. When a man has constructed a nebulous theory, in the building up of which he has used very harsh language against the universal practice of his colleagues, and when the soundness of his theory is questioned in turn, I think it is, to say the least, very regrettable that he should decline to defend his views on so lame an excuse as that experience alone could decide their correctness.

However, Mr. Lane has chosen to retort to my scientific objections by charging me with inaccuracy with regard to the history of a certain case which I have narrated in connection with that part of my first lecture dealing with "breathing exercises," and to leave it to your readers to judge whether I am justified in condemning a treatment "on such a fallacious basis." I am quite ready to meet him on that ground, though I really fail to see that my scientific objections to his theories would be shaken even if I had in good faith committed some trifling inaccuracy with regard to the history of an illustrative case. But where, I now directly ask Mr. Lane, are the inaccuracies to be found with which he charges me? In his version of the case he adds some details, previously unknown to me, which so far as I can judge are *absolutely irrelevant* to the question at issue, but does not cite *one single one* in which I have committed the imputed inaccuracy!

I stated :

1. That the child had marked symptoms of adenoids.
2. That the general attendant and a distinguished surgeon had recommended operation.
3. That another authority—Mr. Lane now says that he himself was that authority—advised breathing exercises.
4. That the latter advice was followed, and that the child went through a long course of such exercises.
5. That she got, while engaged in it, pneumonia, and that her chances were greatly impaired by the still existing impossibility of breathing through the nose.
6. That I was consulted and found the naso-pharynx crammed full with adenoids.
7. That this result was corroborated at the operation by the surgeon first consulted.

In which of these or any other details to be found in my description, and bearing upon the question at issue, have I been incorrect? If Mr. Lane, as I anticipate, can name none, I earnestly hope he will see his way to withdraw the imputation of inaccuracy which he has thought fit to raise against me. Such additions of his own as that he had found "little or no improvement" whilst the child was still under treatment by breathing exercises; that this want of success was "clearly due to failure in carrying out instructions," and that he had written to the patient's father in that sense, are all well enough to serve as apologies for the failure, but they neither entitle Mr. Lane to accuse me of inaccuracy, nor do they alter one tittle in the fact that the naso-pharynx of a child which had been treated for two months for the express purpose of dispersing her adenoid vegetations by a professional who puts herself forward as one of the main exponents of Mr. Lane's theories was, after the lapse of that time, found crammed full with adenoids by two independent observers. *Sapienti sat.!*

I next come to Dr. A. E. Price's chivalrous letter. I wish to speak of his experience with all possible respect, but I must point out that he has not afforded the shadow of a proof that in his cases actual glandular hyperplasia was present, and that this hyperplasia was cured by breathing exercises. Yet this is the real point at issue. I have neither recommended "routine" treatment of adenoids nor contested the general value of breathing exercises. The very contrary in both respects is stated in my first lecture. But I have pointed out at length the important difference between organised hypertrophy and temporary inflammatory swelling of the adenoid tissue, and have explained the apparent success of the breathing exercises in a certain number of cases by the frequency of such inflammatory attacks. Dr. Price, in speaking of his experience, which he himself says is limited, does not enter upon this most essential point at all, and I must therefore respectfully decline to accept his statements as a proof against my deductions.

Finally, the irrepressible Mr. Lennox Browne appears upon the scene. I confess I could not help smiling when I saw his signature. In my experience of controversies with Mr. Browne—which has been rather considerable—I have invariably found that he is a most dangerous advocate—dangerous, I mean, to the cause which he espouses. He resembles the French Legitimists of whom it was said that in their long exile they had "learned nothing and forgotten nothing." Mr. Browne cannot forget, whenever he rushes headlong into a controversy, his old tricks of distorting his adversary's plain meaning, of dragging in matter quite foreign to the subject under discussion, and of obscuring the real issue under a cloud of words, and he has not learnt from bitter and often-repeated experi-

ence that by the adoption of these methods he inevitably in the end damages himself and the cause he advocates. His usual tactics again characterise his present letter, and he has made it extremely easy to expose them ; but before I approach that not very pleasant task I must say that my aforesaid smile deepened into a broad grin when I came near the end of his communication and there found Mr. Lennox Browne solemnly lecturing me on the necessity of "verifying my references." I wonder whether Mr. Browne has ever heard of the *Gracchos de seditione quærentes* !

It is hardly seven years, as all readers of the *Glasgow Medical Journal*, of the *Lancet*, and of the *New York Medical Journal* know, since Mr. Browne got into very hot water over certain liberties which he had taken with regard to literary references, and that he of all men should now feel called upon to sally forth in the garb of a preacher of literary ethics is, I am afraid, rather ill-advised. I will show him presently again, as he might have remembered I have done on previous occasions, that I actually have the disagreeable habit of verifying my references.

For this purpose I must be allowed to somewhat reverse the order of procedure, and to begin by analysing the second part of his post-script. In this Mr. Browne defends himself against the possible suggestion that he had contravened one only of my illustrations of operative intemperance, and assures us that he had "simply taken the first because it was the first." Very simple, indeed ! Almost too simple for anybody acquainted with Mr. Browne's methods of warfare not to suspect that after all there may be a particular reason for his most unusual self-restraint. Let us see.

In the incriminated paragraph¹ I had stated that the funniest part of the whole business was that almost every one of the stalwart fraternity had some pet operation of his own to which he apparently resorted under all circumstances, and that I confessed to serious misgivings, when I "saw it stated, that Dr. X. opened more than 500 maxillary antra within a comparatively few years ; that Dr. Y. found it necessary to employ the nasal saw 'almost daily' ; and that Dr. Z. discovered 'varicose veins' at the base of the tongue or in the pharynx in every third or fourth patient, necessitating, it would appear, in his opinion, the application of the galvano-cautery in a goodly proportion of them."

Mr. Browne finds fault with the "vagueness of these charges" ; the lecturer has "seen it stated" ; he has no personal knowledge, but "what the policeman says is not evidence." An excellent specimen, this, of Mr. Browne's method of distorting his adversary's plain meaning ! I may be "only a poor foreigner," a circumstance of which Mr. Browne, when combating me, rarely omits to remind

¹ *British Medical Journal*, p. 1315, first column.

his audience, but I submit I write a tolerably clear King's English, and I venture to assume, that when I say, "I see it stated," every reader who is not actuated by Mr. Browne's blind animosity against me will interpret this expression in the only natural sense,—namely, that the writer had seen the statements in question *in the writings of the men themselves* against whose tendencies his observations are directed!

And now I will show that this natural interpretation is the correct one, and that I have, indeed, "verified my references." But whilst fully appreciating Mr. Browne's modesty, which prompts him to contravene the first only of my illustrations, he must allow me to be generous and to present him with chapter and verse for *all* the illustrations contained in the sentence over which he makes so merry.

Well, then, the Dr. X. of my sentence stands for Dr. Ziem, who practises in my own native town of Danzig, which according to Mr. Browne's information has a population of about 60,000. In his first statistical paper on the subject, published in March, 1886, Ziem spoke of 37 antral operations performed by him so far.¹ In a second communication published in April, 1888,² he states that he had opened the antrum in no fewer than 227 cases. From this it follows that he must have operated upon no fewer than 190 cases within two years! Even if, as I believe the population of Danzig is much nearer 100,000 than 60,000, the proportion is surely astounding, particularly in consideration of the fact that Dr. Ziem is by no means the only specialist for diseases of the throat and nose in the place. In July, 1895, a paper specially prepared for the occasion by Dr. Ziem was laid before the annual meeting of the British Laryngological, Rhinological, and Otological Association, in which the author states *verbatim*:³

.... My experience is in a large measure confined to suppuration in the maxillary sinus, which cavity I have opened over five hundred times.

The Dr. Y. of my sentence is Dr. Bosworth of New York, who in his *Treatise of Diseases of the Nose and Throat*, 1889, vol. i, p. 303, states *verbatim*:

When this instrument [namely, the nasal saw invented by him] was first made public,⁴ I reported a series of one hundred and sixty-six operations. Since that time I have made almost daily use of it, and regard it as by far the best device we possess for the removal of these obstructions.

¹ *Monats. f. Ohrenheilk.*, March, 1886, pp. 79, 80.

² *Therap. Monats.*, April, 1888, No. 4.

³ *The Journal of Laryngology*, October, 1895, p. 725.

⁴ *New York Medical Record*, January 29th, 1887.

The Dr. Z. of my sentence is Mr. Lennox Browne himself. This insignificant circumstance may possibly explain the unusual self-restraint before alluded to in only challenging my first illustration. In the *Liverpool Medico-Chirurgical Journal* of January, 1896, p. 15, after deploring that the statistics of his hospital hardly showed the proper proportion of the frequency of "lingual varix," probably owing to the deficient enthusiasm of some of his colleagues, he continues *verbatim* :

However that may be, the figures of my own private practice show a much greater frequency. For I find no less than 438 cases of lingual varix in a total number of 1,547 patients suffering from diseases of the throat and nose treated within three years—1893 to 1895 inclusive—a proportion of 28·3 per cent.

And further on, on p. 25, he says *verbatim* :

For the destruction of the varicose veins I invariably employ the galvano-cautery point, the parts being previously rendered insensitive by means of a 10 per cent. solution of cocaine !

I could not find any direction in the section on "Treatment" as to whether this destruction by means of the galvano-cautery was invariably *necessary*, and therefore expressed myself reservedly on that point.

After this I venture to hope that I have "verified my references" to Mr. Browne's complete satisfaction.

The only real subject-matter, so far as I can see, contained in Mr. Browne's letter is his vindication of the justifiability of frequent operations on the antrum, because pus has been found in that cavity by trustworthy observers in a surprisingly large proportion of *post-mortem* examinations.

The disproportion between the frequency of empyema of the maxillary sinus seen during life and after death is, indeed, striking. Whilst such excellent observers as Chiari of Vienna and Lichtwitz of Bordeaux independently arrive at the same result—namely, that empyema of all the accessory cavities of the nose together formed only about 2 per cent. of their large and exclusively specialistic material, the frequency of these affections has been found on the *post-mortem* table in cases of death from all possible causes by E. Fränkel, Harke, Wertheim, and others to amount to between 30 and 40 per cent., or even more.¹ The logical conclusion to be drawn from this fact is, of course, that our clinical knowledge of these

¹ Considerations of space prevent me from entering more fully upon this important question. Those who wish for fuller information may be referred to the interesting papers by Lichtwitz (*Annales des Maladies de l'Oreille*, No. 11, 1899, and by Wertheim, *Archiv für Laryngologie*, vol. xi, Heft 2, 1900.

affections is still very imperfect, and Mr. Browne will, no doubt, argue from that fact that a man who opens more than 500 antra within a comparatively few years is a pioneer of better knowledge—which merit, I wish to state emphatically, I am the last to deny to Ziem, to whom we are, indeed, very much indebted for his enthusiastic work in connection with antral empyema—and that he ought to be imitated, not attacked. But Mr. Browne, unfortunately for himself, has given away his whole case through one of his own quotations. He tells us that E. Fränkel had performed necropsies on 146 patients who had died in the Hamburg Hospital, and were found to be the subjects of sinusitis :

In not a single instance had their condition been recognised during life.

Now, why had this condition not been recognised during life? Surely our Hamburg *confrères* are as able as any doctors in the world to recognise antral empyema, *if it should cause any troublesome symptoms* ; but obviously the fact of the matter was, that in these cases the symptoms *during life* had been either *conspicuous by their absence*, or so *slight* and so *transitory*, that *no treatment had been required*.

And this brings us back to the main argument of my lectures, and to the general question : When is operation indicated in these cases? Surely after extolling, as I have done repeatedly, the better recognition and treatment of empyema of the accessory cavities of the nose as one of the most pleasing and important achievements of modern rhinology, I shall not be suspected to be a “conservative too inactive” with regard to these affections, and as a matter of fact I recommend these operations annually in, I should say, about 1 or 2 per cent. of my patients on the average. But I fully maintain that “no immediate radical operation is necessarily indicated when a drop of pus is seen in the middle meatus of the nose,” and without the least desire to impugn his “rectitude” I confess to serious misgivings as to the indispensability of all his operations, when I read that an enthusiastic surgeon practising in a middle-sized provincial town, has found it necessary to subject within a comparatively few years to one certain operation a number of patients which is simply enormous in proportion to the size of the town in which he lives, and to the number of cases in which the same operation is found indicated by the bulk of his fellow specialists.

The remark just made about the size of the town brings me to Mr. Browne’s naïve question whether it was unreasonable—presuming that he had a hospital appointment—for a throat specialist in a city of 5,000,000 (five million) inhabitants with a large provincial extension to have seen annually, on the basis of Mr. Browne’s facts,

about 1 in every 50,000 of the population suffering with maxillary empyema which called for operation, in a period of five years? My answer is: Yes, it is unreasonable, for it presumes that every one of the patients living in that city of 5,000,000 (five million) inhabitants and suffering from maxillary empyema would flock to that one throat specialist. This I believe to be a preposterous presumption, even if the specialist held a hospital appointment.

I think I have now fully answered Mr. Browne's letter, for I do not consider that his absolutely uncalled-for dragging into this discussion the honoured names of Lister, Paget, and Fergusson, which is only another specimen of his controversial tactics, deserves a reply.

Mr. Browne assures us in his postscript that he had no intention of continuing this correspondence. I gravely doubt whether he will remain faithful to this laudable intention. Should he after all find it desirable to raise some more objections to my contentions I am quite at his disposal.

Before concluding this letter I hope you will allow me, Sir, to make good a very unintentional omission. In my first lecture I said:

I feel sure that before this a protest would have been raised from their midst (that is, from the large moderate section of laryngologists and rhinologists) against what they themselves consider as excessive zeal, had not the same easily intelligible personal considerations, which have for a long time prevented me from speaking out, also, with one exception to which I shall further on specially refer, tied their tongue and hands.

When I penned these lines I confess I only thought of the *direct* protest, raised in a publication, written *ad hoc*, in 1896, by Dr. Herbert Tilley against the abuses connected with the phantasma called "lingual varix." But it has been pointed out to me that I have done scant justice to views, fully analogous to my own, expressed, as far back as 1891, in forcible language by my friend, Dr. P. McBride, in his *Textbook on Diseases of the Throat, Nose, and Ear*, and reiterated ever since when a new edition of that excellent work has become necessary. As a sign of my genuine regret for this omission, permit me to quote some of the most important of his statements, and to express my delight at finding myself so fully in accord with one of the most justly respected of British laryngologists and otologists. Dr. McBride says:

While we as rhinologists know what a normal nose ought to be, we are not aware of the exact deviation from the normal which may exist without discomfort in any given case. Thus I venture to say that if a hundred persons who complain of no discomfort referable to the nasal passages were examined, abnormalities would be detected in a very large proportion. More or less hypertrophy of the mucous membrane and irregularities of the septum can, while men are constituted as they are, and not according to what the rhinologist conceives they ought to be, hardly be

classed as morbid conditions. My own practice is to consider and treat such conditions only when they produce discomfort.¹

Rhinology has made rapid strides of late, and operative rhinology has accomplished much for the benefit of humanity. It has, however, added something to the suffering of mankind. As a student of rhinology for more than a decade, with considerable clinical material at command, I know what the ideal normal nose should be. As an aurist, who examines the anterior nares in most cases, I also know full well how far this organ may deviate from health, if a normal nasal mucosa be implied by the use of this term, without occasioning any symptoms referable to the part. I would, therefore, contend that at present we know as the normal an ideal which is not often met with. Indeed, if ten persons, who in answer to leading questions state positively that they are not in any way troubled by symptoms referable to their noses, be examined, the probability is that more than half will show such evidence of disease—for example, spines of the septum, thickening of the mucosa over the turbinated bodies, etc., as would lead to severe operative measures being advised by many rhinologists, if they were to carry out what they advocate. This excessive operative zeal appears to me to be a great danger, threatening as it does the credit of our profession as a whole, and rhinology in particular, etc.²

It has generally been the implied teaching of modern otology that any obstructive nasal disease is liable to cause obstruction of the Eustachian tube or exhaustion of air within the tympanum. Now this is to a certain extent true; but if carried through its logical termination to energetic operative procedures in all cases is likely to end in discrediting otology.³

I have laid some emphasis upon this point, because it would appear that some aural surgeons and rhinologists are under the impression that fibroid changes in the middle ear can be dissipated by operating on the nasal passages.⁴

I am, etc.,

FELIX SEMON.

Wimpole Street, W., Nov. 18th.

(b). *Letter to the Editor of the "British Medical Journal," published January 11th, 1902.*

SIR,—The chief results of the discussion which has followed the publication of my lectures on "The Principles of Local Treatment in Diseases of the Upper Air Passages" appear to me the following:

- (1) The discussion has enabled the profession to form an opinion of its own on the justice or otherwise of my statements.
- (2) It has shown that the views I expressed are shared by a number of distinguished specialists in all parts of the country.
- (3) It has produced an open revolt of the otologists against the pretensions of the modern rhinologist.
- (4) It has shown that there is no scientific defence of the treatment by "breathing exercises" in cases of genuine adenoids.

¹ *Diseases of the Throat, Nose, and Ear*, 1st ed., 1891, pp. 227-8.

² *Ibid.*, pp. 265-6.

³ *Ibid.*, p. 566.

⁴ *Ibid.*, pp. 567-8.

(5) It has not brought forward one single sound scientific argument against the principles advanced in my lectures.

Of these results, I consider the first the most important one. The development of laryngology, rhinology, and otology has within the last ten or twelve years almost exclusively taken place in special journals and special societies, not only in this country, but practically everywhere. That this system entails certain important advantages, I am the last to deny. The specialist who publishes his experiences in a journal devoted to his speciality thereby secures a much larger and more international circle of expert readers than if his publication had appeared in a general medical journal. Amongst the advantages of a special society are the following: it usually, though unfortunately not always, produces a certain *esprit de corps*; it enables its members to make the personal acquaintance of fellow specialists, and facilitates a direct exchange of opinion between them; it gives the opportunity of eliciting in doubtful and difficult cases the views and advice of a large number of experts; and, above all, it preserves to science the records of numerous interesting cases which, without its existence, would be in all probability simply lost. These advantages are so great and so obvious that they induced me some ten years ago to act myself as prime mover in the foundation of a special Society—namely, the Laryngological Society of London.

But already, then, I neither disregarded nor underrated the one great danger which very possibly may outweigh all the advantages offered by purely specialistic journals and gatherings: the danger of *isolation* of the speciality! No truer words were ever spoken than those of my great master, Virchow, in the address he gave at the jubilee meeting of the Berlin Medical Society on October 28th, 1885, when he said: "Amongst us has arisen the large army of specialists, and it would be useless, or at any rate fruitless, to oppose this development; but I think I ought to say here, and I hope to be sure of the consent of you all when I say it, that no speciality can flourish which separates itself completely from the general body of science; that no speciality can develop usefully and beneficially if it does not again and ever again drink from the general fount, if it does not remain in relationship with other specialities, so that we all help one another, and thereby preserve for science, at any rate, even if it should not be necessary for practice, that unity on which our position rests intrinsically, and I may well say, also, with regard to the outside world."

To prevent the isolation against which Virchow so justly warns, I insisted and carried when the rules of our new Society were framed that no set papers should be read, but only cases be shown at its meetings. By the insertion of this clause I hoped (1) to

preserve to the general medical societies laryngological and rhinological contributions of more than purely specialistic interest; (2) to keep alive the interest of the bulk of the profession in the scientific progress of laryngology and rhinology; and (3) to keep us specialists in actual touch with general medicine.

I much regret having to confess that my hopes have been but very imperfectly realised. It is an incontestable fact that for the last eight or ten years very, very few laryngological or rhinological papers of general interest have been read before general medical societies in London, and that the number of more important laryngological and rhinological papers published in English general journals has very seriously diminished.

The consequences of such, however unintentional, isolation of a speciality do not, of course, become conspicuous at once; but after a time they make themselves inevitably felt. The profession loses what little interest it had in the development of the special branch, and the specialists themselves, whilst insensibly losing touch with general medicine, become more and more apt to have their judgment warped by their mental concentration on one idea. From one or a few casual observations the more enthusiastic or fanatical ones amongst them construe a theory which soon they persuade themselves to be a fact. On that unsafe and unsound basis fresh—even more exaggerated—theories are built; and within a few months, or at most years, fantastical doctrines are evolved, which are preached with a dogmatism and an amount of self-assertion more than sufficient to make outsiders believe that some really great truth had been discovered which must be accepted as gospel. What else are the various excesses I combated in my lectures than concrete illustrations of the reality of the chain of events I have just sketched?—The profession has now had an opportunity such as, owing to the voluntary isolation of laryngology and rhinology, it has not had for a good many years to form an opinion of its own on these matters, and I have good reason to believe that it has welcomed this opportunity.

(2) A most valuable feature of the discussion has been the generous support given to my views by specialists in various parts of the country. This has shown that the statements made in my lectures were not the impressions of a single, possibly prejudiced, individual, but that I have merely expressed in words what others have long felt. The controversy has indeed developed into a pitched battle between the moderate and the radical sections of specialists, and has justified what I said in my first lecture—namely, that the ever-growing feeling against local over-activity in this territory of medicine was “shared by no one more strongly than by the large moderate section of laryngologists and rhino-

logists, who from the nature of their calling have probably more opportunity to see what is going on than the profession at large, and who resent it the more keenly as their whole speciality is held responsible for the excessive activity of the radical section."

(3) Most important in this connection is what I have called the "revolt of the otologists against the pretensions of the modern rhinologist."

Personally I see in this feature one of the most material gains resulting from the discussion. That the pretensions of the modern rhinologist with regard to the influence of minor degrees of obstruction of the nose upon affections of the pharynx, larynx, and lower air passages are unfounded and untenable, I hope I have shown sufficiently clearly in my lectures, but as I am not an aurist myself, expert support upon the otological part of my contentions was most desirable, and I am very glad that it has been so amply and so positively forthcoming. Whilst thanking every one of the aurists who have supported my contention that it was "unintelligible how a slight degree of obstruction of the nose proper, particularly when one-sided, could be believed to exercise the disastrous influence upon the ventilation of the middle ear which I so often saw ascribed to it," I feel I do no injustice by more particularly drawing attention once more to the important letter of Dr. McBride which was published in the *British Medical Journal* of December 14th, 1901. Personally, I have always had a very strong impression when patients came to ask my opinion as to whether removal of a spur from the septum, or a similar intranasal operation was likely to have a beneficial effect upon what was evidently labyrinthine disease, that the enthusiastic rhinologists who had recommended such operation must have a "most elementary knowledge as to the diagnosis and prognosis of ear disease." But it will be useful to the profession, as it was to me, to know that this impression is shared by an otologist whose competence to speak in this matter nobody will deny. It is also not a little remarkable in this connection that Dr. McBride's carefully scheduled challenge to those who put their trust in attacking the nasal passages for the relief of deafness has received no reply. The profession will now be able to judge whether his fear "that we must conclude that a vast amount of nasal operating has been done with no result, and that we may consider without injustice that those who are thus advocates for the cure of otherwise incurable diseases have no case," is justified or not.

Before concluding, however, this part of my summary, I wish to state once more, to avoid all possible misunderstanding, that by opposing the pretensions of some modern rhinologists, nothing could be further from my intention than to belittle the achievements

of modern rhinology. The progress of our science with regard to nasal diseases has within the course of the last fifteen years indeed been very remarkable. We have learnt that a certain number of reflex neuroses *may* be of nasal origin; our operative technique in nasal diseases has been considerably improved; the histology and pathology of new growths in the nose have been revised, and to a certain extent reformed; we have had valuable information with regard to nasal tuberculosis, to nasal diphtheria, to the micro-organisms met with in the nose under normal and pathological conditions, and to the escape of cerebro-spinal fluid through the nose; and, above all, our knowledge with regard to the pathology, diagnosis, and treatment of affections of the accessory cavities of the nose has been very materially increased. All these and similar achievements are certainly greatly to be respected, and I yield to nobody in gladly appreciating them; but they do not, in my deliberate opinion, justify in the least the ambitious claims of the modern rhinologist concerning the overwhelming importance of nasal disease, and its often exaggerated influence upon affections of the throat and ear.

(4) There is nothing further to be said about the question of "breathing exercises" in cases of genuine adenoids. Scientific objections to this form of treatment, and courteous requests for an explanation of its supposed mode of action have remained equally unheeded; and everybody must now form his own opinion on the original attack upon operative interference in cases of adenoids, and on the method which it was proposed should be substituted for it.

(5) A letter was published in the *Journal* of January 4th, 1902, expressing disappointment at the personalities into which the discussion had degenerated, and with this feeling I entirely agree. Considering that my lectures embodied almost exclusively the results of my own personal experience, that I touched upon so great a variety of topics, and that concerning most of these topics opinions differ considerably, one might fairly have expected an interesting discussion in which my views would be combated by equally good or better reasons. As a matter of fact, however, a curious medley of artillery has been brought to open fire upon my contentions: unproven theories, unfounded charges of inaccuracy, ill-applied quotations, personal aggressiveness, would-be smartness, pretensions to superior knowledge; in short, everything except—sound scientific arguments. Nevertheless, I feel sure the discussion has not been in vain. For the very nature of the opposition must have shown the readers of the *Journal* that the dogmatic assertions of the radical section rest on no more solid basis than on the *ipse dixit* of each of its self-constituted representatives, and that they

collapse the moment that they are seriously gone into. This, I venture to think, is one of the most important fruits of the discussion.

I refrain from entering upon minor questions of operative details, or upon matters which are alien to the subject of my lectures.

But I should like in conclusion to say a word with regard to the future. No doubt my lectures, and the discussion which followed them, have shown that at present a state of things exists with regard to operative intemperance equally undesirable in the interests of the profession and of the public. The remedy in my opinion lies in a return to closer touch between the specialists and the general profession. Room enough will remain for special societies, and for their exercising a beneficial function, if matters of exclusively technical and specialistic interest continue to be treated in them ; but what we require is to bring the fruits of our labours more frequently before the profession at large in general societies and in general medical publications, to receive the stimulating criticism of those not exclusively engaged in one narrow sphere of work, to be reminded that there are other things to consider than exclusively local conditions, and to preserve, to speak in Virchow's words, "that unity upon which our position rests intrinsically, and, I may well say, also with regard to the outside world."—I am, etc.,

FELIX SEMON.

Wimpole Street, W., Jan. 3rd.



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